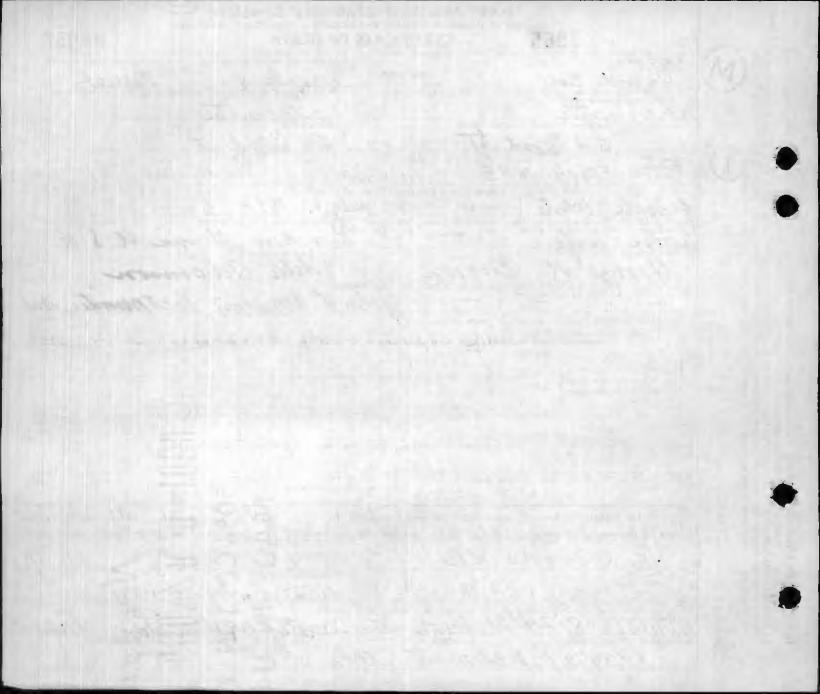
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CENTRES OF DEATH

NOMO

	CERTIFICATE OF DEATH	98936				
)	1. PLACE OF DEATH O. COUNTY O. STATE D. COUNTY O. STATE D. COUNTY D. COUNTY O. STATE D. COUNTY D					
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmannella C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	; RURAL and give nearest town)				
	d. NAME OF HOSPITAL (IF not in hospital, give street address) OR INSTITUTION 5.4 Band T- 5.4 Band St.	e. IS RESIDENCE ON A FARM? YES NO				
	(Type or print) EDITH MAE ARMACOST DEATH AUGU					
	female widowed Divorced July 13 1892 9. AGE (In year last birthday)	Months Days Hours Min.				
	JOD JUSUAL OCCUPATION (Give sind of work done lob. KIND OF BUSINESS OR INDUSTRY 17 BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) Bowdom Slenger	12. CITIZEN OF WHAT COUNTRY				
	15. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 173 INFORMANT ACTUAL	ddress				
	(Yes, no, or unknown) (If yes, give wor or dotes of service) John L-amalost, W.	st menter, ma				
	18. CAUSE OF DEATH [Enter only one couse per line for (0), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A MOROPHIC LATERAL SCLEROSIS	INTERVAL BETWEEN ONSET AND DEATH				
	Conditions, if any, which (b) (b)					
	cause (a), stating the under DUE TO lying cause lost. (c) (c)	CIVENIAN BART YAND IN WAS ALITOPS				
	ССАТІО	PERFORMED? YES NO				
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Caunty) (State				
	Haur a. m. p. m. 19 While Nat while of work at work					
21. 1 certify that (1) (this haspital) attended the deceased fram Art 1 1960, to accurred at 7 p.M., fram the causes and an the date						
	220 SIGNATURE ATTENDING M.D. PHYS. ATTENDING MED. OF PHYS. 220 ADDRESS 221 ADDRESS	SIGNE SIGNE				
	NAME (FYGE) A MES THEREOF / 23c, NAME OF CEMETERY OF CREMATORY 23d, LOCATION (City, 10W)	M) n, er county) (State)				
	BURIAL (Specify) 8/24/61 Mostmunter Cemtley westmin	GISTRAR'S SIGNATURE				
		eding d. Term				



TO HOSE I OR ATTENDING PUXSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be usined by the hospife attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campiantly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remaye carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, an remayal, and in any seent, within 72 hours after death.

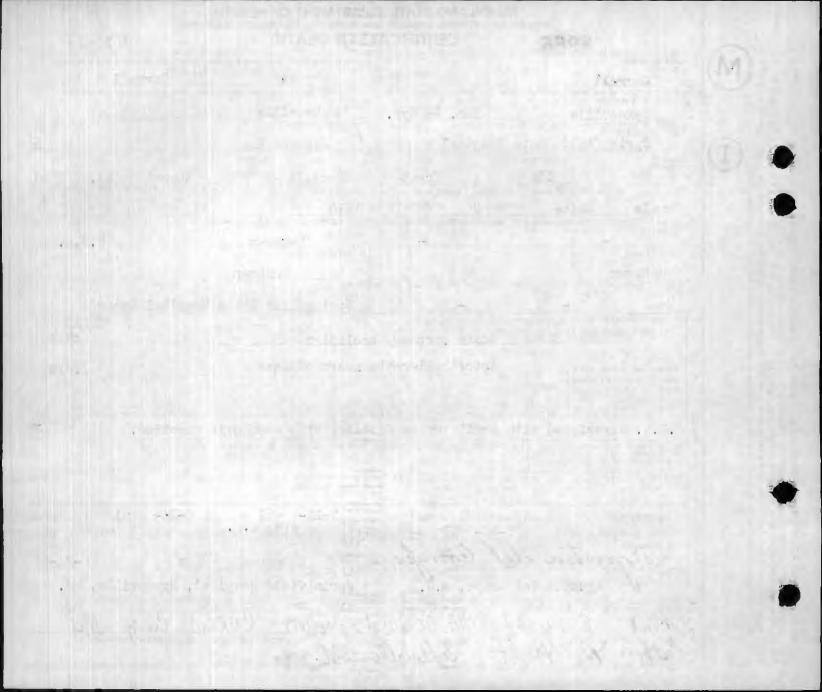
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118957

1. PLACE OF DEATH o. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Carroll							
	(If autside carporate lim	its, write	c. LENGTH OF STAY IN	V 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn)							
RURAL and give nearest town)					Sykesville							
d. NAME OF HOSE	SVIIIA	nive street	Imo. 13 dy	S.	d. STREET ADDRESS	TTe			-	e. IS RES	SIDENCE	
Springfield State Hospital Oakland Road								ON A FARM? YES NO				
					-							
3. NAME OF DECEASED		rst	Middle		tosi	4. DATE OF	Man	ith .	Do	,	Yeor	
(Type or print)	Ida		Trott		Becraft	DEATH	augu		24	-	19 61	
5. SEX	6. COLOR OR RACE	7. MAR	RIED NEVER MARRIED	B. C	ATE OF BIRTH		9. AGE (In years last birthday)	Months	Doys	Hours	ER 24 HRS	
Female	White	WIDOW	VED DIVORCED		1876		85 yrs.			710013		
10a. USUAL OCCUPAT	TION (Give kind of work orking life, even if retired	done 10b	. KIND OF BUSINESS OR	INDUSTRY	11. BIRTHPLACE (State	or foreign c	country)	12. CIT	IZEN OF	WHAT	COUNTRY	
Guing most of m	on king tile, even if telliet	"	1000		Unkr	กดพท			II	S.A		
13. FATHER'S NAME				1	4. MOTHER'S MAIDEN							
Unknow	70				TT-	nknown						
	VER IN U. S. ARMED FO	RCES? 16	SOCIAL SECURITY NO.	17. INFO		TIVITOWIT	Add	ress	_			
(Yes, no, or unknown)	(If yes, give wer or dates of			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 TT - 1 I	3.0		2		
No	-		•••	1	Springfie	Id Sta	te Hospit	AL RE		_		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							ONS	ET AND	DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Acute coronary occlusion House								rs				
420,0 DUE TO								1				
Conditions, if	ony, which)	ol .	Arterioscler	otic	heart disea	ase				Years		
gove rise to	immediale (Due T											
	couse (a), stating the <u>under-</u>											
Z PART II. O	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY											
C.B.S. a	C.B.S. associated with senile brain disease, with psychotic reaction.											
	WAS UNDERLYING A NG CAUSE OF DEATH FY MEDICAL EXAMINER)	200. 01.	SCRIPT HOW HOOK! OC	CORRED. (I	iner notate of thisty in							
Haur o. m	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Haur o. m. p. m. 19 at wark at wark 19 at											
21. I certify th	21. I certify that (I) (this haspital) attended the deceased fram. 7-11-, 1961, ta 8-24-, 1961, that (I) (we) las											
	saw the deceased alive an 8-24-1961, and that death accurred a 2:300, from the causes and an the date stated above											
220 SIGNATURE			11 1	/	ATTENDING A		60000 01				26. DATE	
Cla	agustin del Compo					MED.	STAFF PHYS.			8-2	4-61	
220 PHYSICIANS	Agustin d	el Ca	ampo, M.D.		Springfiel	ld Hos	pital, Sy	kesvi	ille	, Md		
23a. BURIAL, CREMAT		OF ,	23c. NAME OF CEMET	TERY OR C	REMATORY	23d. LQC#	TION (City, town,	of county)		(Sta	10)	
BURIA Speci	(4) 8-26.	61	Old OAK	IANd	Cemetery	Cr.	ARROLL (County	1	Md	4	
24. FUNERAL DIRECTO	OR'S SIGNATURE	.01	ADDRESS	-11	M / 25a. REC	D BY REGIS	TRAR 25b. REGI	STRAR'S SI	IGNATU	RE		
auther	74. /Ya	ont	sykeru	rele	DATE DATE AND	IG 2 8 '6	1 0	11 9	16-			

VR A15 (4) 1SM 9/S9



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH ROCT funeral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Allegany Maryland Carroll by the and 2 s MARYLAND death b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give neerest town)
Sykesville, Md. 60 days Cumberland, Md. Pages 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addrass) d. STREET ADDRESS 310 Harrison Street Springfield State Hospital 3. NAME OF Middle 4. DATE Month DECEASED comple DEATH Aug. (Type or print) Ellen Mary Bohn carbon 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER I YEAR | 5. SEX B. DATE OF BIRTH lest birthdey) Female April 2. WIDOWED DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY! II. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) KM Maryland U.S.A. None Allegany, & Housewife 13. FATHER'S NAME please attending James Youngblood Ida Appold 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give we ror detes of service) Springfield State Hospital No attending physician, as been signed by the 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c),) PART I. DEATH WAS CAUSED BY: Aspiration-Pneumonia IMMEDIATE CAUSE (e) burial-transit DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), steting the underlying certificate has ceuse lest. the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY 315 Schizophrenic reaction, catatonic 080 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert I or Part II of itam IB.) 20e. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH detached of Healt 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form,) 20f. (City or town) fectory, street, office bldg., etc.) While Not While Hour a.m. et work at work 21. I certify that (I) (this hospital) attended the deceased from 6-20-61 19 to Aug. 19 19 61 that (I) (we) last 19.61, and that death occured at 11:20 fBM the causes and on the date stated above. Aug. saw the deceased alive on..... ATTENDING DIRECTOR PHYS. PHYS. M.D. FUNERAL 22d. ADDRESS NAME (Type) Dr. Naci Buyukansul Springfield State Hospital 23s. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23e. BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify) Hillcrest Burial Park Cumberland, Md.

TO FUNE director, 1 be filed v VR A15 (4) 15M 9/60

Burial

24 FUNERAL DIRECTOR'S SIGNATURE

Wayne George,

Cumberland, Md.

256, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE

(County)

IS RESIDENCE ON A FARM?

YES NO K

196]

IF UNDER 24 HRS.

19

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

(Stete)

22b. DATE 19.

YES IN NO .

DATE AUG 2 4 '61

arthur & Kours

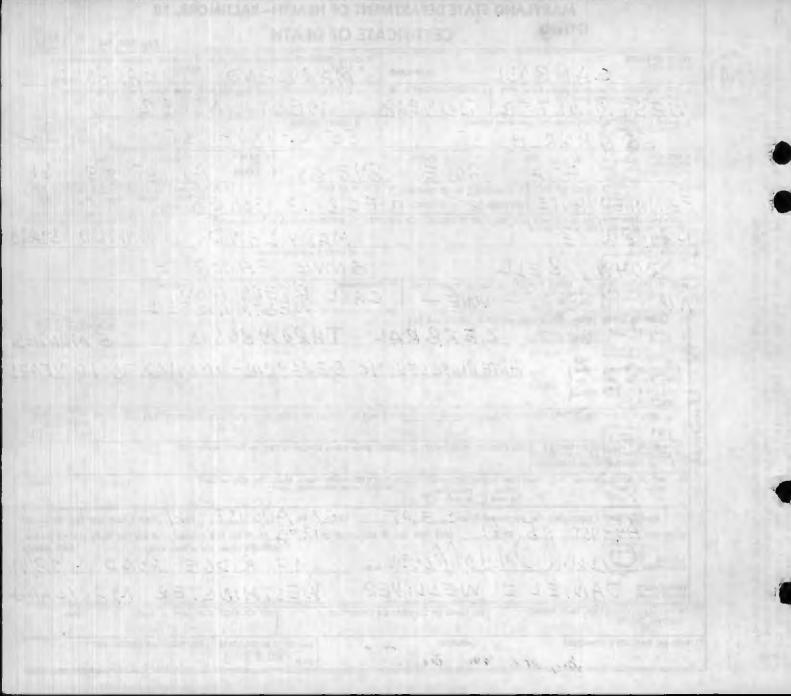
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08959

1. PLACE OF DEATH O. COUNTY Carroll			MARYL	AND	2. USUAL RESI	nd (Wi	here deceases	lived. If instituti b. COUNTY Fred	an: Residen	ce before ad	norssian)
RURAL ond give		its, write	c. LENGTH OF STAY II		c. CITY OR		outside corpo	rate limits, write R	URAL and g	give nearest t	own)
d. NAME OF HOS OR INSTITUTIO Eldersbu	SPITAL (If not in haspital, g	jive street	2 mont	ns.	d. STREET	street ADDRESS 1 W.Pabrick St		1011-		1 0	RESIDENCE N A FARM?
3. NAME OF DECEASED (Type or print)	Ida Fi	rst	Middle Bell		Burn		4. DATE OF DEATH	August	oth	Day 15	Yeor 1961
s. sex Female		7. MARI	RIED A NEVER MARRIE	[B. DATE OF BIRT	Н	1885	9. AGE (In years lost birthday) 75 yrs.	IF UNDER Months	1 YEAR IF U	-
Housewife 13. FATHER'S NAME		done 10b.	At Home	INDU	Frede	rick,	Maryla NAME	nd		S.A.	AT COUNTRY
Benjami 15. WAS DECEASED E	n Cutsail EVER IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.	17, IP	EL1Z FORMANT	abeth	Burk	Add	ress		
(Yes, no, or unknown)	(If yes, give war or dates of a	iervica)	one	Hai	vey C.B	urns.	331 W.	Patrick	St.F	rederi	ck.Md.
Canditions, if gave rise to cause (a), stati lying couse la	ng the <u>under-</u>	AR	PERTENSIVE TERIOSCLERO	TIC	HEART D	ISEAS	0		WENT INT BAD	ONSET A	
FICATION AND AND AND AND AND AND AND AND AND AN			CRIBE HOW INJURY OF						10141141777	PE	RFORMED?
OR CONTRIBUTION (IF EITHER, NOT	WAS UNDERLYING AND CAUSE OF DEATH IFY MEDICAL EXAMINER										
20c. TIME OF INJ Haur a. r	10	While			ACE OF INJURY street, office			y ar lown)	(1	County)	(5tot
21. I certify to saw the dece 220. SIGNATURE	that (1) (this haspital eased alive on 15	Augu	ded the deceased st 1961, and	that c	Feb. death accurre M.D. ATTENDIN	ed at 4.1		5 August the causes ar		61, that (e date sta	
22c. PHYSICIAN		on,	Jr., M.D.		22d. ADDI Syk		le-2,	Maryland			
230. BURIAL, CREMA REMOVAL (Spec	TION, 23b, DATE THERES	4	23c. NAME OF CEME			Cem.		TION (City, town,	or county)	Maryl	(State)
24 FUNERAL DIRECT	on & Son, 106	E.C	ADDRESS hurch St.Fr	ede	rick,Md.		IG 1 7 '		ISTRAR'S SI	10	

VR A15 (4) 15M 9/59

· multiple · 15/10/18 = 1 - 1 A ANTHONY OF THE SECOND I BOYCE DECEMBER OF THE PARTY OF THE PA The state of the s AND THE RESIDENCE OF THE PARTY MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



AARYLAND STATE DEPARTMENT OF HEALTH **DIVISION OF STATISTICAL RESEARCH** PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decreesed lived, If institution: Residence before edmission) COUNTY Frederick Carroll MARYLAND Maryland b. CITY OR TOWN (if outside corporete I m ts, c. CITY OR TOWN (If outside corporete I mits, write RURAL end give neerest town) c. LENGTH OF STAY N 16 write RURAL and give neerest fown) 3mos.28 dys. Frederick Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO DE 701 Fairview Avenue Springfield State Hospital DECEASED OF 19 61 (Type or print) Cacalia August Margaret Cooney DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. So birthdey) Months | Devs Hours December 4, 1871 Female White WIDOWED TO DIVORCED [10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Maryland Housewife 13. FATHER'S NAME III. MOTHER'S MAIDEN NAME Maria Archer Cather William S. Eyerly 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) ((fyesgivewerordelesofservice) Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: two days IMMEDIATE CAUSE (6) Terminal pneumonia (b) Arteriosclerotic cardiovalvular disease Conditions, if eny, which vears geve rise to Immed eta causa DUE TO (a), stating the underlying (c) Arteriosclerosis, generalized and severe. vears PART II. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? C.B.S. associated with senile brain disease, with psychotic reaction. NO [206. ACCIDENT WAS UNDERLYING ___ 206. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of Item 18.)
OR CONTRIBUTING __ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dev. Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) While _Not While Hour e.m. at work at work 21. I certify that (i) (this hospital) attended the deceased from. 4-13-1961 8-11-101, that (I) (we) last 8-119.61, and that death occurred at 9:00. From the causes and on the date stated above. saw the deceased alive on..... 22b. DATE 22e. SIGNAJUT ATTENDING 8-SIGNED DIRECTOR PHYS. X PHYS.

L DIRECTOR: As 3 should be del the State Dept. o eth. FUNERAL tor, page

by the land 2 seed

papers

physician

ng physician.

has

certificate

please

within carbon

ន្ទុំខ្ញុំនិ VR A15 (4)

22c, PHYSICIAN'S

REMOVAL (Specify)

Burial

NAME (Type)

23c. NAME OF GEMETERY OR CREMATORY Loudon Park Cemeterv

ADDRESS

Buyukunsal, M.D.

23d, LOCATION (City, lown or county)

(Stele)

Springfield Hospital, Sykesville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Naci

23a. BURIAL, CREMATION, | 23b DATE THEREOF

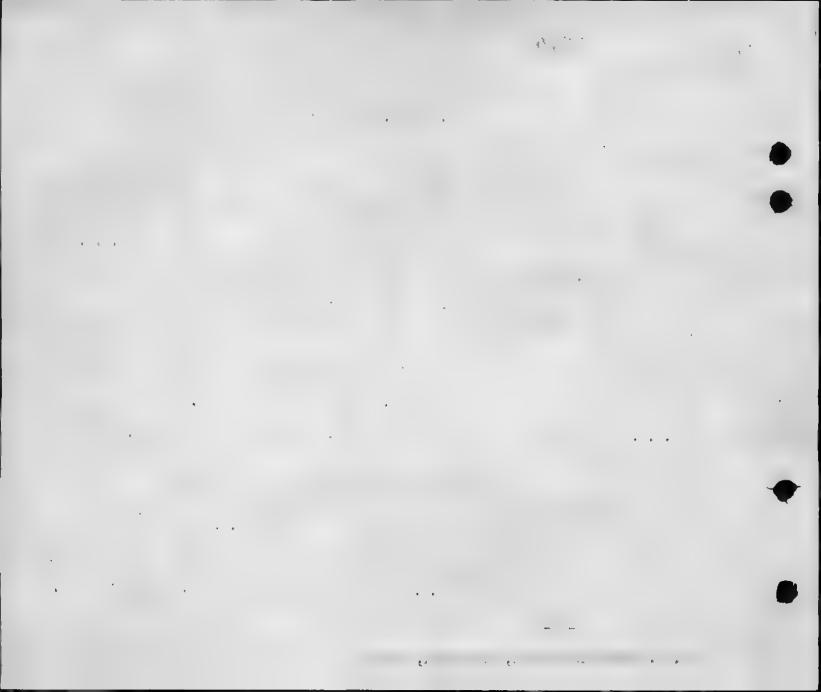
M. R. Etchison and Son, Frederick, Maryland

22d. ADDRESS

Maryland 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Chilling & Krous

Baltimore



RYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before edmission) e. COUNTY slay is no....eral director. Page 4 for your files. b. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate lim'ls, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outs de corporata limits, write RURAL and give nearest town) write RURAL and give neerest lown) Rural-New Windsor Rural - New Windsor d. NAME OF HOSPITAL OR INSTITUTION (f not in hospital, give street address) b. IS RESIDENCE ON A FARM? be retained the State B Denning YES NO Road Denning Road 3. NAME OF DATE Month DECEASED 2 with the OF (Type or print) LARRY DEATH RRANCIS CRUMBACKER August 27 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS. Page 5 m f and 2 w last birthday) Months WIDOWED Male yrs. 10e. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) within 24 hours III. Give Pages I Laborer Farm Maryland pages I form PM3. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Woodrow F. Crumbacker Carrie Scheller 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17, INFORMANT Office along with Mr. Woodrow F. Crumbacker. " in pencil in Item 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-fransit ONSET AND DEATH IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which tbl Examiner's (gave rise to immediate cause (a), stating the underlying couse last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(8) 19. WAS AUTOPSY PERFORMED? v 206, DESCRIBE HOW INJURY OCCURED, (Enter natura of injury In Part I or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | M.V. with fixed object CAUSE OF DEATH should be forwarded to the Chief PUNERAL DIRECTOR: Page 3 its designated agent, prior to buri MEDICAL 2Dd. INJURY OCCURRED 2De, PLACE OF INJURY (Homa, farm, 20f. (City or town) (County) (State) While Not While of work at work /factory_street, office bldg., etc.) execute the certificate, Inspection 7 21. I certify that I took charge of the remains described above, held an Autopsy Inquiry and in my op nion death resulted from. Natural causes Accident X Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER SIGNATURE QUILLE ASSISTANT MEDICAL EXAMINER DATE SIGNED 2.8 Address (Street, city, town, or county) CÉMETERY OR CREMATORY 22d. LOCATION (City, town, or country) Ã REMOVAL (Spacify) Q 40 P 8-29-1961 Sams Creek Brethren Carroll Co. Marylan Ē **V5. A15ME** AUG 3 0 '6' arthur S. Kraus C. M. Waltz, Winfield, Maryland 5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

8973

rs after death. Page 4

Poges 1 and 2 should be filed with

TO HOSP OR ATTENDING PATEURAN: The faw requires that the dmath certificate be executed may be used by the hasplic attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and camp. Expanse 3 shauld be detached far use as the burial-transit permit. Then please remave capter appers. the State Board at Health prior to burial, crematian, ar remaval, and in any event, within 72 have after

VR A15 (4) 15M 9/59

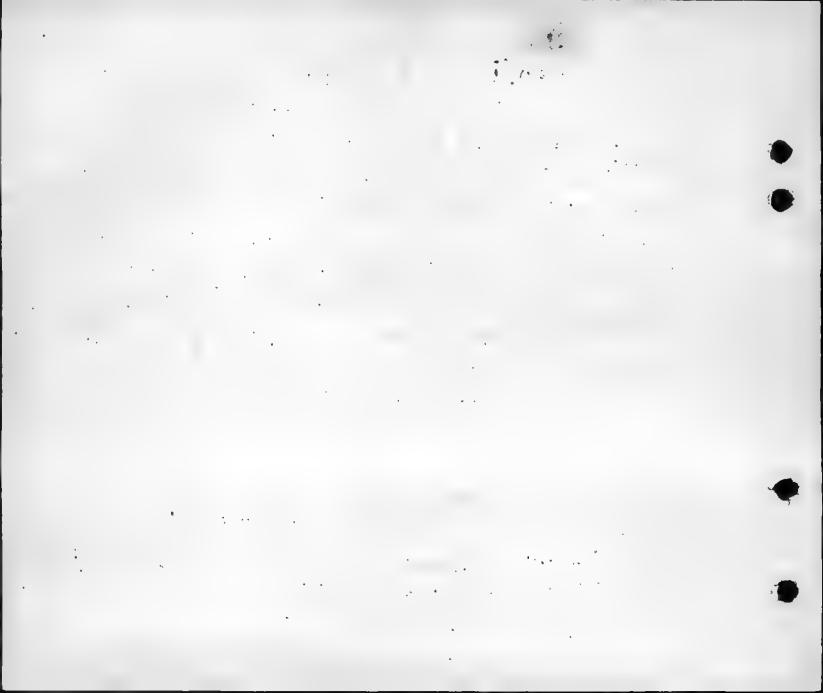
ys after death

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]	PLACE OF DEATH COUNTY CARROLL MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution Reco. STATE 6 COUNTY	sidence before admission)
	b CITY OR TOWN (if outs de corporole limits, write RURA) and give nearest town)	c. CITY OR TOWN III outside corporate limits, write RURAL	and give nearest town)
	d. NAM OF HOSPITAL (If not in hospital, give street address) OR (MSTITUTION	727 & marlyn au.	e IS RESIDENCE ON A FARM? YES NO 12
	NAME OF DECEASED (Type or print) ELIZABETH Middle	DECKER 4. DATE Month	Day Year 9 196/
-	Jemale Hute WIDOWED DIVORCED	May 7, 1880 9. AGE (In years (MU) lost birthdoy) 8 / yes. Mon	NDER 1 YEAR IF UNDER 24 HRS ths Days Hours Min
Ŀ	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRIES OF WORKING LIFE CONTROL - LEGERAL	STRY 11. BIRDAPLACE (Stole or foreign country) 12	CITIZEN OF WHAT COUNTRY?
13.	Joseph Decker	14. MOTHER'S MAIDEN NAME	· · · · · · · · · · · · · · · · · · ·
	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN. 40F or unknown) (If yes, give wor or dates of service)	No. Kendrick Chance	as above
	18. CAUSE OF DEATH [Enfer only one couse per line for (o), (b), ond (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (o)	ailure, arteriosclerchi	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which) (b) beent des.	arterin cleronis gen.	7-19-6
	gove rise to immediate couse (a), stating the under- lying couse lost DUE TO (c)		8-9-61
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN	PART I(o) 19. WAS AUTOPSY PERFORMED? YES NO
L CERTIFI	206. ACCIDENT WAS UNDERLYING DOBUGED 206. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING DOBUGED CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter nature of injury in Part I or Part II of item 18.)	
MEDICAL		ACE OF INJURY (Home, form, 20f (City or town) clory, street, office bldg., etc.)	(County) (State)
	21 Leartifus that (1) (this baseled) attended the deceased from	7-19 1961 to 8-9	./-1
	21 I certify that (!) (this haspital) attended the deceased fram saw the deceased alive an 7 1961, and that d		19 G.L. , that (1) (we) last the date stated above.
	saw the deceased alive an 7-9 1961, and that d	MED PHYS MED DIRECTOR PHYS.	
	saw the deceased alive an 7-9 1961, and that d	leath accurred and M. from the causes and an	the date stated above.
230	saw the deceased alive an 7-9 1961, and that d 220. SIGNATURE Acrossed & Hall 22c. PHYSICIAN'S	M.D. PHYS MED DIRECTOR PHYS. 22d ADDRESS	the date stated above. A DATE S GNID



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



directa funeral attending

cate



ary filled to by the funeral director, Poges 1 and 2 should be filed with

8976

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

08967

		COUNTY OKKALL	MARYLAND	2 USUAL RESIDENCE (Where deceased lived a. STATE	b. COUNTY	before admission)
	ŀ	CITY OR TOWN (If outside corporate limits, write RUBA) and give parest tayout	C. LENGTH OF STAY IN 16	c City OR TOWN of outside corporate In	mits, write RURAL and give	e nearest town)
(,	6. NAME OP/HOSPITAL (If not in hospital, give street OR INSTITUTION	oddress)	d. STREET ADDRESS		e IS RESIDENCE ON A FARM? YES NO DE
1	1	NAME OF DECEASED Type or print) MARY	1AY GA	SSMAN 4. DATE OF DEATH	Qua, Month	Day Year 9 61
_	/5. S	Fremele White WIDOW	DIVORCED	Oct. 1, 18/1 8	d birthday) Manths D	YEAR IF UNDER 24 HRS oys Hours Min.
		USUAL OCCUPATION (Give kind of wark done 10b. during most of warking life, event retired)	HOME STATE	me	112.CITIZE	S. A.
		William Ber	1	Mary Belle	son	
		WAS DECEASED EVER IN U.S. ARMED FORCES? 36.	SOCIAL SECURITY NO. 17. III	no William Hawke	Address - Olyk	usville my
		1B. CAUSE OF DEATH [Enter only one couse per lin PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)	refor (o) (b), and (c)	lure, arteriose	leifue	INTERVAL BETWEEN ONSET AND DEATH
		Conditions, if ony, which gave rise to immediate (b) full	Adin, O The	art block, arteres	Sclevis	7900
	_	lying couse lost. DUE TO (c) (c)	erlyed,			9 Aug 61
	FICATION		CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CON	IDITION GIVEN IN PART 1	(o) 19 WAS AUTOPSY PERFORMED? YES NO
	CERT	OR CONTRIBUTING A CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D. (Enter nature of injury in Port I ar Part II of	item 1B.)	
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d II Haur o.m. 19 While at work	Not while for	ACE OF INJURY (Home, form, 20f. (City ar to ctory, street, office bldg., etc.)	wn) (Co	unty) (State
		21 I certify that (I) (this haspital) attends saw the deceased alive an	/ /	leath accurred 360M, from the	dug , 1960 causes and an the	, that (I) (we) last date stoted above
		220. SIGNATURE HENVILLE	HOW 4	M.D. PHYS. DIRECTOR PH	AFF YS.	GA A SIGNED
		NAME (Type) HOWARD	E. HALL	Alhemil	le, ml	<i>l</i>
No.	Ľ	BUR.AL, CREMATION, 236 DATE THEREOF REMOVA, (Specify) 8-11-6	Bellie Cha	uch of God Wenter	City, town, or county)	ale, md
	24.	FUNERA DIRECTOR'S SIGNATURE	Hyperselle,	250. REC'D BY REGISTRAR OATE AUG 1 5 '6!	256 REGISTRAR'S SIGN	

TO HOSY OR ATTENDING (*) SICIAN: The law requires that the death certificate be executed thin 2s may be a fined by the haspite attending physician.

TO FUNERAL DIRECTOR: After this verificate has been signed by the attending physician and campiately fille page 3 should be detached for use as the burial-transit flermit. Then please remaye carban papers. Poges the State Board of Health priar to burial, cremation, ar remayal, and in any event, within 72 haurs after death. VR A1S (4) 3SM 9/S9

ers after death. Page 4



BYLAND STATE DEPARTMENT OF HEALTH W. PRESTON STREET, BALTIMORE 1, MARYLAND Division of STATISTICAL RESEARCH FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH L PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission e. COUNTY Page e. STATE **b.** COUNTY Carroll Marvland Carroll MARYLAND b. CITY OR TOWN (I outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (.! outside corporate Fmrts, write RURAL and give nearest town) al director. write RURAL and give nearest town) Sykesville Lyrs. 2mos. 22days Finksburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Springfield State Hospital YES NO THE 3. NAME OF elbbiM 4. DATE Month Yeer DECEASED OF (Type or print) DEATH Morrill Preston 19 61 Greene August 200 With 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE III Years | IF UNDER 1 YEAR IF UNDER 24 HRS. Age 5 m. I and 2 w may 2 wif last b rthdey) Months 65 yrs. Male White WIDOWED [DIVORCED [March 2, 1896 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Wood-worker Maryland U.S.A. File pages 1 13. FATHER'S NAME form PM3. 14. MOTHER'S MAIDEN NAME 8. Give Lewis Greene Catherine Allgire 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unknown) ! (If yes give we ror detes of service) Springfield Hospital Records. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Asphyxia due to occlusion of the larynx by food. -Minutes. Office DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying Examiner cause lest. pesn PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY C.B.S. assoc with convulsive disorder without qualifying phrase. Fracture of the skull with subdural and epidural hemorrhage. PERFORMED? NO pinous 20e. EXTERNAL CAUSE WAS 20b. DESCR.BE HOW INJURY OCCURED. (Enter neture of Injury In Part I or Part II of Item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. Chief 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (Steta) aga Id of factory, street, office bldg., etc.) While Not While to the OR: Pa Svkesville at work et work Hospital Carroll Md. prior execute the certificate, 21. I certify that I took charge of the remains described above, held an Autopsy 🔼 Inspection 🔼 Inquiry 🔣 and in my opinion O should be forwarded FUNERAL DIRECT Natural causes Accident X. Suicide Homicide Undetermined manner death resulted from: CHIEF MEDICAL EXAMINER ACTUAL. ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S James T. Marsh. M.D. 8/1/61 should NAME (Type) Address (Streat, city, town, or county) 22a. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (State) REMOVAL (Specify) 40 9 FUNERAL DIRECTOR REC'D BY REGISTRAR 74b. REGISTRAR'S SIGNATURE VS. A15ME ariling & Heart 5M 7/59

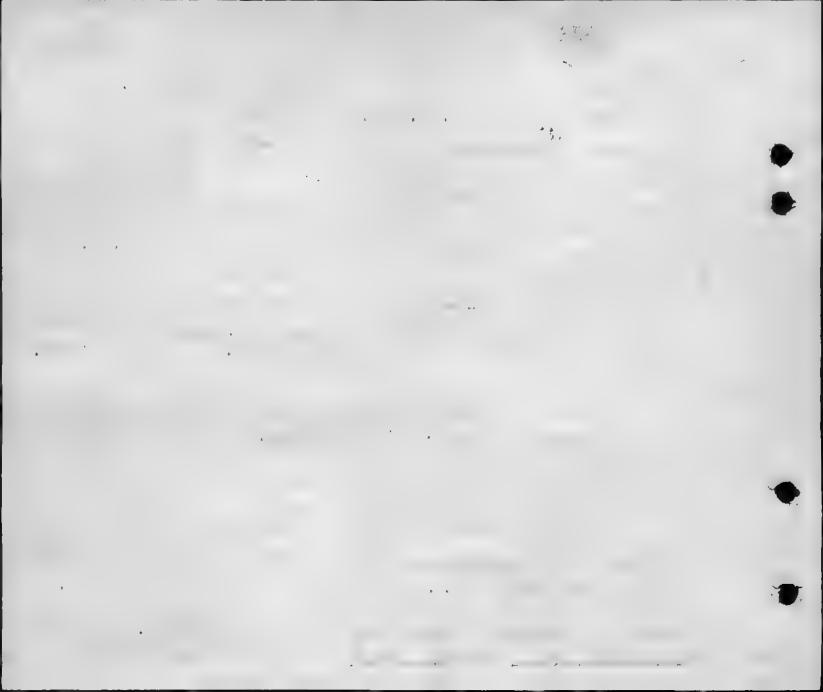


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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF THE STATE DE PARTIMENT OF TEACH DE LA MARYLAND CERTIFICATE OF DEATH

1	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased I ved, If institution, Residence before edmission)							
1	o. COUNTY Carroll MARYLAND	o. state b. county Balto. City							
-	b. CITY OR TOWN (if outs de corporete limits. write RURAL end give neerest town) c. LENGTH OF STAY IN 16								
	Sykesville 5yrs.2mo.14dys	Baltimore 6							
1	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, g ve street eddress)	d STREET ADDRESS o IS RESIDENCE ON A FARM?							
VI.	Springfield State Hospital	5906 Cedonia Avenue							
\parallel	3. NAME OF First Middle	Last 4. DATE Month Day Year							
7	(Type or print) Helen Theodora	Greller DEATH August 9 1961							
ľ	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED								
	303- 170-44-	Hovember 28-1908 See Dirthdey) Months Deys Hours Min.							
ľ	10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Y 11 B RTHPLACE (County & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY?							
	Housewife -	Maryland U.S.A.							
١	Joseph Honacki	Frances Modrak							
ł	15. WAS DECEASED EVER IN J S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	NFORMANT Address							
ł	No (Ifyesgive werordetes of service)	Springfield Hospital Records							
	18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).]	INTERVAL BETWEEN							
ı	PART I. DEATH WAS CAUSED BY: Acute myocardial	infarction, cause unknown,							
ı	possibly spasm of	coronary arteries. Minutes.							
1	Conditions, if eny, which (b)								
ı	gave rise to immediate cause								
ı	(c), stelling the underlying Due 10								
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?							
	Involutional psychotic reaction. Dial	oetes Mellitus.							
١	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO INVOLVED TO DEATH BUT NO INVO								
- 1									
1		CE OF INJURY (Home, ferm, 2Df. (City or town, (County) (State) ory, street, office bldg., etc.)							
1	Hour e.m. While Not While Fact	ory, and on one of the original or of the original							
ı	21. 1 certify that (I) (this hospital) attended the deceased from.	. 5-25- 1956, to							
١	saw the deceased alive on	death occured at ?: 30h, Prom the causes and on the date stated above							
1	22e. SIGNATURE	ATTENDING MED. STAFF 22b. DATE							
	D: Male D. Durntunde "	D PHYS. DIRECTOR PHYS. X 8-9-61							
	27c PHYSICIAN S NAME (Type) Mond Dynnigal M. D.	Springfield Hospital, Sykesville, Md.							
1	Naci buyukunsai, M.D.								
	23e. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY REMOVAL (Specify)	OR CREMATORY 23d. LOCATION (City, town or county, (State)							
	Paris 8-14-1961 Gardens of E	aith Baltimore Co. Maryland							
\	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
	Toosahn Furnal Home 7401 Below Ro	DATE DATE							



rs after death. Page 4

CIAN: The law requires that the death certificate be executed

director,

the funeral

physician and

the attending

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ertificate has been signed by as the burial-transit permit. ttending physician

> detoched far prior

ned by the haspital DIRECTOR: After It

Then please remave Earbon

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With in

or removal,

cremation,

1. PLACE OF DEATH

CERTIFICATE OF DEATH 8979 2 USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. COUNTY p. STATE b. COUNTY MARYLAND Carroll Maryland Balto. Co. b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) Svkesville 22 days Baltimore 22

d NAME OF HOSPITA	d NAME OF MOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS					e IS RES		
	Springfield State Hospital					400 Bayside Drive					NO 🔂	
3 NAME OF DECEASED (Type or print)	Id.	llian	Middle Shultz	;	Grumba	4. DATE OF DEATH	1	Month Augus	t 20	•	Year 19 61	
s. sex Female	6. COLOR OR RACE White	7. MARRIED T	NEVER MARRIED [_ L	uary 5. 18	896	9 AGE (In y last birthd	ears IF JI ay) Mar yrs.	NDER I YEAR	IF UNDE Haurs	R 24 HRS Min	
10a USUAL OCCUPAT.ON (Give kind of wark dane 10b. KIND OF BUSINESS OR INDL during most of warking life, even if retired) Housewife				NDUSTRY	OUSTRY 1) BIRTHPLACE (State or foreign country) 12 CITIZ West Virginia					ZEN OF WHAT COUNTRY?		
13. FATHER'S NAME	ick Shultz			11	. MOTHER'S MAIDEN	NAME						
15. WAS DECEASED EVER (Yes, no. or unknown) (If	IN U. S. ARMED FOR yes, give wor or dates of s	RYVOR)	-	7, INFOR		Celia S Leld Ho		Address Reco				
PART I. DEATI	H WAS CAUSED BY: MMEDIATE CAUSE (or DUE TO	Arte	rioscler		heart dis				Y	ears ears	DEATH	
gave rise to im cause (a), stating th lying cause last	gave rise to immediate cause (a), stating the under-							Minutes				
₹ C.B.S. ass	C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction YES IN NO											
200 ACCIDENT WAS OR CONTRIBUTING E (IF EITHER, NOTIFY M	200 ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
ZOc. TIME OF INJURY Have a, m, p m,	20c. TIME OF INJURY Month, Day. Year 20d. INJURY OCCURRED Haur a. m. p.m. 19 While Nat while at wark					(County)		(\$tate)				

SIGNED

-20-61

(State)

7-28-1961 to 8-20-, 1961, that (I) (we) last 27 | certify that (1) (this hospital) attended the deceased fram.___ 8-20-19 61, and that death accurred at 11:10 from the causes and on the date stated above saw the deceased alive an ATTENDING MED DIRECTOR

21c PHYSICIAN S NAME (Type) 22d ADDRESS Agustin del Campo. M.D.

Springfield Hospital, Sykesville, Md. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county)

230 BURIAL, CREMAT ON, 236 DATE THEREOF REMOVAL (Specify) 8-24-61 24 FUNERAL DIRECTOR'S SIGNATURE

Meadow Ridge **ADDRESS**

Dorsey, Maryland 25a, REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE

Ullrich Funeral Homes, Dundalk, Md.

DATE AUG 23 '61

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page 3 should be detoche the State Board of Health may be TO FUNER VR A15 (4) 15M 9/59



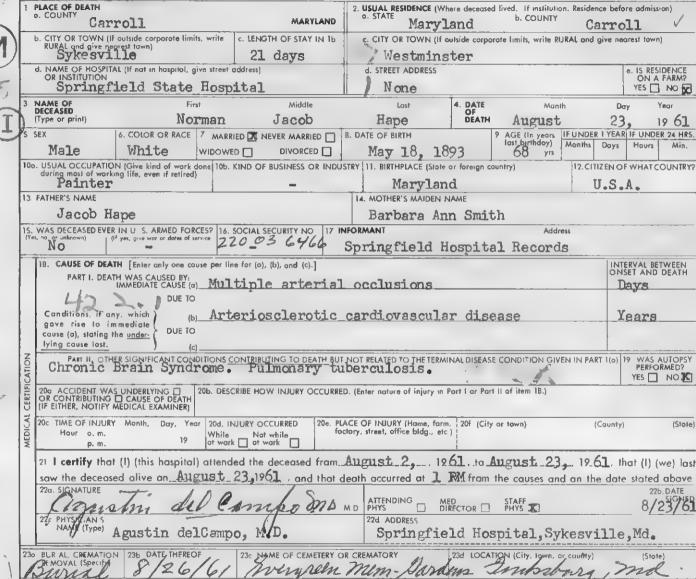
1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
r out	~	CERTIFICATE OF DEATH Reg. Dist. No. (1897)
director	(M)	1. PLACE OF DEATH o. COUNTY O. COUNTY O. STATE MARYLAND 2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) O. STATE MARYLAND 2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) O. STATE MARYLAND
the funeral dire		b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
the fu		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR A FARM?
P P P P P P P P P P P P P P P P P P P	17:	3. NAME OF First Middle , Lost 4. DATE Month Day Year
fille oges 1		(Type or print) ROSALIE NEBECCA HALBERT DEATH AUGUST 6, 1961
camp,		FEMALE WHITE WIDOWED DIVORCED FEB, 7, 1889 lost birthdoy) Months Doys Hours Min.
ian and camplication		HOUSEWIFE OWN HOME MARYLAND USA
physician and remave carbon	T	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME SARAH SANE SANE
ng physician remove ca	4	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17, INFORMANT Address (If you, give wor or dates of service) A A D FAMILIA RECARDS
tendi pleas		18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]. PART I. DEATH WAS CAUSED BY: ONSET AND DEATH
the of Then		MAMEDIATE CAUSE (a) Car de la faclure, arlleus chroses,
ned by rmit.		Conditions, if only, which (b) Chrome Chram Dyndrom, fractured left
cion.		lying couse last. (c) bup (repaired) all cubilie, anderress.
physical physical photos be principle.		FERFORMED? YES NO
ificate the by	Ò	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
his err		Ustate) Zoc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of
hospith After the		21. I certify that I attended the deceased from 18 April, 1957, to 6 Aug., 1961, that I last saw the deceased
by the CTOR: detacl		alive on 19 , and that death accurred at 100 AM, from the causes and an the date stated above ADDRESS (Street, city or town, stole) DATE SIGNET
A) DIRE hould be	22	ACTUAL SIGNATURE AFWARD BALL M.D. Spendly Tall 6Ag61 PHYSICIAN'S
2000	,	NAME (Type) 220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d (OCATION (City favo or county) (State)
T Page		PEMOVAL (Specify) AVG. 8, 1961 DRUID RIPGE CEM, PIKESVILLE, MD, 23, FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
YS A15 (4) 15M 9/55	12.1	John Burns Sons Town, Med. DATE AUG 10'61 Circles & Krans



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If ins o. STATE o. STATE b. COU

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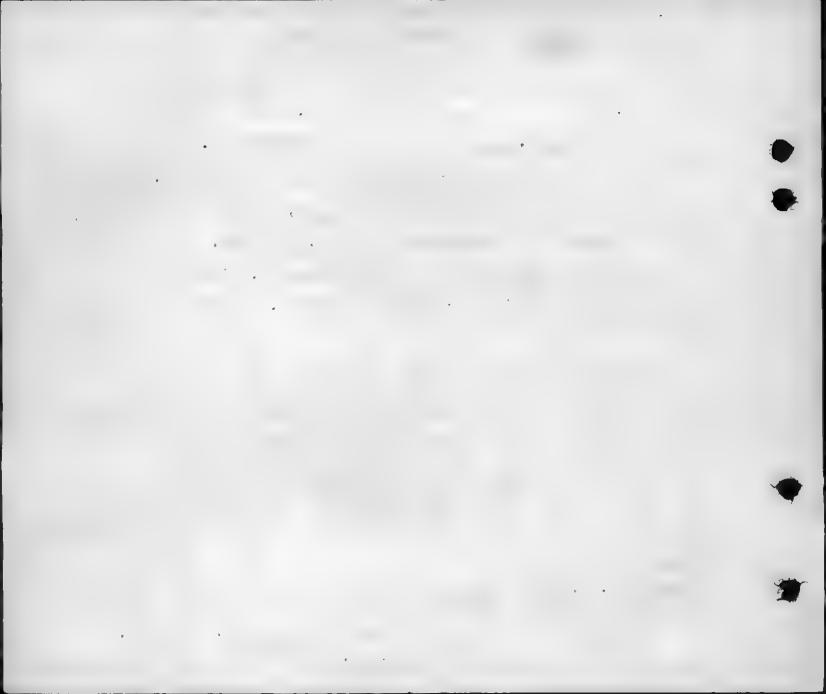
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been signed

after death. Page



1	, 5		MARYLAND STATE DEPARTMENT OF HEALTH—B	BALTIMORE, 18	
4 .52		L	CERTIFICATE OF DEATH	Reg. I	Dist. No. 118973
director,	V	1	PLACE OF DEATH 2. USUAL RESIDENCE (Where de	eceased lived. If institution, Resid	ence before admission)
il dire			Carroll Maryland G. STATE Maryland	6 b. COUNTY CA	rroll
death.	NI			carparate limits, write RURAL and	
after de the fun should		L	Mt. Airy	v	
	V		d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
d 2	X	L	Paradise Ave. / Paradise	e Ave.	YES NO
by by		3.		ATE Manth	Day Year
fille		L	(Type or print) Leroy - Harrison		6 1961
2			SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH	9. AGE (In years IF UNDI lost birthday) Months	R 1 YEAR IF UNDER 24 HRS.
			Male White WIDOWED DIVORCED June 12. 190	06 55 yrs	Days Hours Min.
cam pop		100	a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fore during most of working life, even if retired)	eign country) 12, C	ITIZEN OF WHAT COUNTRY
and de			irack foreman Railroad Mt. Airy	. Md.	USA
te be ian al carba after	(F)	113.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME		
rtificat physici mave baurs	(\perp)		Oliver R. Harrison Clara E.	. Rider	
Physical Phy		(Ye	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT IN 19. (If yet, give wor or deres of service)	Address	
th c ding se r		<u> </u>		<u>larrison</u>	Item 2
dea Hen Plec			18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	4	INTERVAL BETWEEN
the G			IMMEDIATE CAUSE (a) CERANARY Mrance	rees	Sudden
that by th t. Th y eve			YAIIY DUE TO OI OIT;		1
es de la company			Conditions, if any, which gave rise to immediate (b) Chr. Tieda exactic's		1 440
guir igne			coese (a), stating the under-		
one and		z	lying couse lost. (c)		
hysin bysin bysin hysin val,	:	15	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DI	ISEASE CONDITION GIVEN IN PA	PERFORMED?
The The hor		CERTIFICATION	200 ACCIDENT WAS UNIDEDIVING IT 20% DESCRIBE HOW INHIBY OCCUPABLY (S	Don't Had Mary 202	YES NO
AN: ndin cote		ERT	20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I of Injury in Port	or rorr it or (tem ig.)	
or Hitte		4	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f.	10 harries and a second	
use noti		MEDICAL	Haur a.m. While Not while foctory, street, affice bldg., etc.)	. (City of town)	(County) (State)
Cree this		Σ	p. m. at was a at was		
Affe riol,				9 16 , 1961, that I	
the stack	1			from the causes and on	
AT CT of r	/		SIGNATURE CM Man Vaule MD. MAN	SS (Street a city or town, stote)	DATE SIGNED
OR DIRECT				ciry from	8-1-7-6
A Tor			PHYSICIAN'S C.'M. VanPoole	V	
OSPIT JNER JNER JNER JNER JNER JNER JNER JNER	6	220	O. BURIAL CREMATION, 12% DATE THEREOF 220 NAME OF CEMETERY OF CREMATORY 224 1	OCATION (City, town, or county)	
I DI O O	200		Burial 8/19/61 Pine Grove	261 4 4	
5 5 5 ==	41	23.	FUNERAL DIRECTOR'S SIGNATURE / ADDRESS 240 RECID BY P	EGISTRAR 246. REGISTRAR'S S	
VS A1S (4) 1SM 9/SS	Y		PUNERAL DIRECTOR'S SIGNATURE ADDRESS DAMA CUB, Md. 240. REGD, BY R. DATE		2. Kraya
13/W 7/33			TO THE STATE OF TH		/Valla



MARYLAND STATE DEPARTMENT OF HEALTH W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institutions Residence before edmission) a. COUNTY a. STATE b. COUNTY Carroll MARYLAND Laltimore -aryland b. GITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If outside corporete limits, write RURAL and give nearest town) write RURAL and give nearest lown) Sykesyille Yrs I Lonth Baltimore City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Hospital II60 E. Hoffman St. YES NO 3. NAME OF 4. DATE Middle Last Month DECEASED OF (Type or print) DEATH 1961 James Havlik AGE (In years | IF UNDER I YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH IF UNDER 24 HRS. last birthdey) Months | Devs Male WIDOWED [DIVORCED 10e. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retired) Worker Shipyard Hunbary Austria 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Havlik, Annie 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) ((Ifyes give wer or deles of service) 215-09-4832 Springfield Hospital Mecords 18. CAUSE OF DEATH [Enter only one cause per line for (e,, (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: ilateral Pulmonary Tuberc losis , Far Advanced Years IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) geve rise to Immediate causa DUE TO (a), stating the underlying ceusa last. PART II OTHER 5 GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO T 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury In Part I or Pert II of item 18.) Month, Doy, Year, J 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY 20f. (City or town) (County) (Stete) Not While factory, street, office bldg., etc.) While Hour a.m et work et work 19.7., and that deeth occured at 3.3 Mt, from the causes and on the date stated above. saw the deceased alive on ... B DATE ATTENDING STAFF SIGNED PHYS. DIRECTOR PHYS. 22d. ADDRESS NAME (Type) Dr. Naci N. Guyukensal 238. BURIAL, CREMATION, | 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) (State)

Redeemer Cem

ADDRESS

_Home.

1. Baltimore Md.
258. REC'D BY REGISTRAR'S SIGNATURE

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DATEUG 2 2 '61

director, page 3 director, page 3 be filed with the J. VR A15 (4) 15M 9/60

REMOVAL, (Specify)

24 FUNERAL PEPECTOR'S SIGNATURE

Hurial

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Then

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certificate



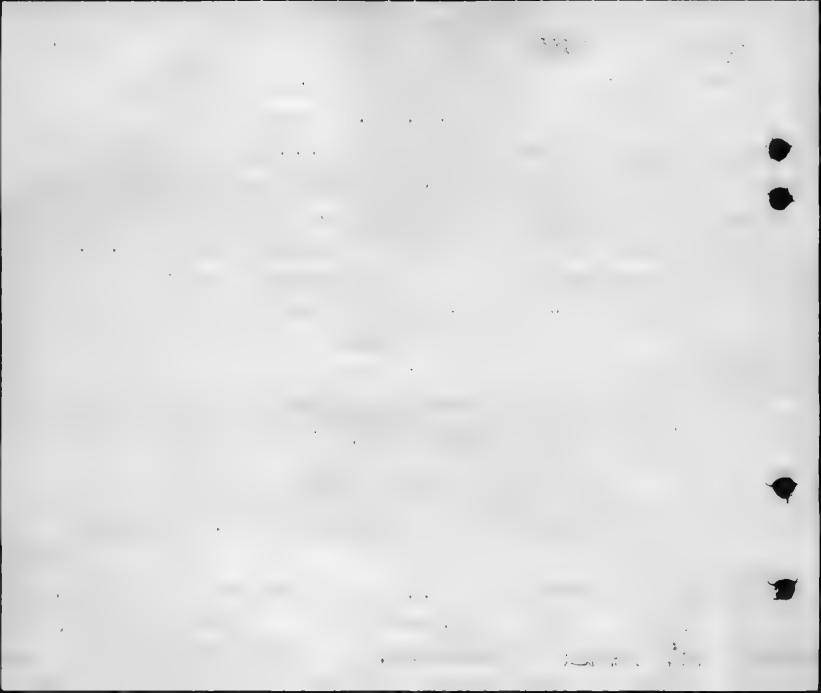
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 8984 funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed I'ved, If Institution: Residence before edmission) e. COUNTY b. COUNTY by the and 2 Carroll MARYLAND Maryland Allegany b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporete limits, write RURAL end give necrest town) write RURAL and give nearest town) Sykesville 8yrs.2mo.13dys Millmin d. NAME OF HOSP, TAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Springfield State Hospital YES NO 3. NAME OF 4. DATE Middle Mosth Yeer DECEASED OF (Type or print) DEATH 19 61 Ada Hey Imun August 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In yeers | IF JNDER 1 YEAR | IF UNDER 24 HRS. last birthdey) Months DIVORCED DE May 28, 1889 Female White ling physician in lease remove of in any event 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | II, BIRTHPLACE (County & State, or foreign country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ple John Heylmun

15. WAS DECEASED EVER IN J.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT

Address (Yes, no, or unkown) | (If yes give wer or detes of service) Springfield Hospital Records hospital or attending physician certificate has been signed by the r use as the burial-transit permit. prior to burial, cremation, or rem 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Multiple Pulmonary infarcts Weeks IMMEDIATE CAUSE (e) **DUE TO** Conditions, if eny, which Auricular fibrillation Unknown geve rise to immediate cause DUE TO (e), stelling the underlying cause lest. Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(6) 19. WAS AUTOPSY .B.S. associated with circulatory disturbance, other than cerebral PERFORMED? NO NO arteriosclerosis, with psychotic reaction.

200. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of Item 18.)
OR CONTRIBUTING | CAUSE OF DEATH | (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year (County) (Stete) factory, street, office bldg., etc.) While Not While Hour e.m. et work et work 4 may be retained I. DIRECTOR: 3 should be defined the State Dept. o 22b. DATE 22e. SIGNATURE **ATTENDING** SIGNED 8-2-61 DIRECTOR PHYS PHYS. page with th 22d. ADDRESS 226 PHYSICIAN'S NAME (Type) HOS PUNE FUNE rector, p Julian Radzykewycz, M.D. Springfield Hospital, Sykesville, Md. 23e. BURIAL, CREMATION, | 23b. DATE THEREOF 1 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) ង្វីម៉ូង St. Peters Cemeterv Westernport 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL-DIRECTOR'S SIGNATURE VR A15 (4) Westernport, Md. 15M 9/60

ARYLAND STATE DEPARTMENT OF HEALTH



FOR STATE HEALTH DEPT, TO DI. TY MEDICAL EX. CINER: This certificate should be executed within 24 hours after. Th. If a slay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Peges 1, 2, and 3 to the wineral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages, and 2 with the State Board of Heather or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. VS. A15ME

5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

OCCUPANDICAL FYAMINER'S CERTIFICATE OF DEATH

() 8978

	PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If Institution, Re	asidanca belore admission)
	Carroll MARYLAND	a. STATE Maryland b. COUNTY Al	legany
	b. CITY OR TOWN ('flourside corporate I mits, c. LENGTH OF STAY IN 1b write RURAL and give nearest lown)	c. CITY OR TOWN (If outside corporete limits, write RURAL and	
_	Sykesville 1 mo., 8 days	Cumberland	À.
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, g ve street address)	d. STREET ADDRESS	15 RES DENCE ON A FARM?
	Springfield State Hospital	R#4, Christine Road	YES NO X
	NAME OF First Midd.e	Lest 4. DATE Month	Day Year
	(Type or print) Allie Beatrice Booher	Hott DEATH August	28. 1961.
5.		DATE OF BIRTH 19. AGE (In years IF UNDER 1)	
	Female White W.DOWEDE DIVORCED	April 26, 1897 70 yrs. Months D	eys Hours Min.
10a	. USUAL OCCUPATION (GIVE kind of work 10b. KIND OF BUSINESS OR INDUSTR		ZEN OF WHAT COUNTRY?
do	Housewife At Home	Maryland	.S.A.
13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	.0.1.
	Frank Booher	Amanda Heckenberty	
15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I	NFORMANT Address	
110	s, no, or unkown) ((fyasgive warordelesofservice) No None	Springfield Hospital Records	
	18. CAUSE OF DEATH Enter only one cause par line for (e), (b), end (c).]	- The second of	TINTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema		Days
	DUE TO	THE RESERVE THE PROPERTY OF THE PERSON OF TH	Days
	Conditions, if any, which \ (b) Arteriosclerotic h	apart disansa	Years
Н	gave rise to immediate cause	CELT & COLORDS	
	(a), stating the underlying DUE TO cause test. (c) Generalized arteri		V
1 1			
			Years
NOL	C.B.S. assoc. with cerebral arteriosclere	T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1,a) 19. WAS AUTOPSY PERFORMED?
FICATION	C.B.S. assoc. with cerebral arterioscler	or related to the terminal disease condition given in Part osis with psychotic reaction.	1,0) 19. WAS AUTOPSY
ERTIFICATION	C.B.S. assoc. with cerebral arteriosclere 208. External cause was primary of contributing to peath but no cerebral arteriosclere	T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1,a) 19. WAS AUTOPSY PERFORMED?
AL CERTIFICATION	C.B.S. assoc. with cerebral arteriosclere 206. External cause was primary of contributing to peath but no cerebral arteriosclere 206. External cause was primary of contributing to peath but no cerebral arteriosclere 206. External cause was primary of contributing to peath but no cerebral arteriosclere 206. External cause was primary of contributing to peath but no cerebral arteriosclere. (External cause of peath but no cerebral arteriosclere)	or related to the terminal disease condition given in Partiosis with psychotic reaction. Internature of injury in Part I or Part II of item 18.) June 18.	1.a) 19. WAS AUTOPSY PERFORMED? YES NO
1 " 1	PARTI OTHER S.GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO C. B. S. assoc. with cerebral arterioscler 20e. External Cause was PRIMARY or CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e PLA Hour a.m. While Not While	ory, street, office bidg., atc.)	19. WAS AUTOPSY PERFORMED? YES NO (State)
MEDICAL CERTIFICATION	C.B.S. assoc. with cerebral arteriosclere 206. External cause was primary or contributing of death autoriosclere 206. External cause was primary or contributing or contribution of the contribution of	or related to the terminal D. SEASE CONDITION GIVEN IN PART OSIS WITH PSychotic reaction. Internature of Injury in Part I or Part II of item 18.) July 15 CE OF INJURY (Home, form, 201. (City or town) ory, street, office bldg., atc.) Sufficiently Communication of the communicati	19. WAS AUTOPSY PERFORMED? YES NO (State)
1 " 1	C. B. S. assoc. with cerebral arteriosclere 206. External cause was primary or contributing to peath but no cerebral arteriosclere 206. External cause was primary or contributing to peath but no cerebral arteriosclered arteriosclered or contributing to peath but no cerebral arteriosclered or cerebral arteriosclered or contributing to peath but no cerebral arteriosclered or cerebral arteriosclered or contributing to peath but no cerebral arteriosclered or contributing to peath but no cerebral arteriosclered or contributing to peath but no cerebral arteriosclered or contributing to contributing the cerebral arteriosclered or contributing to cerebral arteriosclered or cerebral arteri	or related to the terminal D. SEASE CONDITION GIVEN IN PART OSIS WITH PSychotic reaction. Internature of Injury in Part I or Part II of item 18.) July 15 CE OF INJURY (Home, form, 201. (City or town) ory, street, office bldg., atc.) Sufficiently Communication of the communicati	19. WAS AUTOPSY PERFORMED? YES NO (State)
1 " 1	C.B.S. assoc. with cerebral arteriosclere 206. External cause was primary or contributing of death autoriosclere 206. External cause was primary or contributing or contribution of the contribution of	or RELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSS WITH PSYCHOTIC REACTION. Inter nature of Injury in Part I or Part II of item 1B.) LE OF INJURY (Home, form, 201. (City or town) Ory, street, office bidge, atc.) Sufficiently Inspection I Inquiry .	YES NO (Steta)
1 " 1	C. B. S. assoc. with cerebral arteriosclere 206. External cause was PRIMARY or CONTRIBUTING CAUSE OF DEATH. 206. TIME OF INJURY Hour a.m. 207. Time Of Injury Month, Day, Yeer 204. Injury Occurred 206 Plan While of While at work at work 21. I certify that I took charge of the remains described above, he death resulted from: Natural causes Accident Suici	or RELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSS WITH PSYCHOTIC REACTION. Inter nature of Injury in Part I or Part II of item 1B.) LE OF INJURY (Home, form, 201. (City or town) Ory, street, office bidge, atc.) Sufficiently Inspection I Inquiry .	YES NO (Steta)
1 " 1	C. B. S. assoc. with cerebral arteriosclere 20e. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (E. S. C. S.	or RELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSSIS WITH PSYCHOLIC REACTION. Internature of Injury in Part I or Part II of item 1B.) LILL L. L	YES NO (Steta)
1 " 1	PART J OTHER S.GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO C. B. J. ASSOC. WITH CEPEDRAL ARTERIOSCIEPT 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING OF CAUSE OF DEATH. 200. TIME OF INJURY Hour a.m. S. J.	TRELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSSIS WITH DSYCHOLIC reaction. Internature of injury in Part I or Part II of item 1B.) LILL J	YES NO (Steta) And in my opinion DATE SIGNED
MEDICAL	C.B.J. ASSOC. WITH COPED TAI ATTENTIONS CONTRIBUTING TO PEATH BUT NOT CO.B.J. ASSOC. WITH COPED TAI ATTENTIONS CONTRIBUTING TO PEATH BUT NOT COPED TAIL ATTENTIONS CONTRIBUTING TO PEATH BUT NOT CONTRIBUTING TO COURSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20cd, INJURY OCCURRED TO PEATH AND A POPULATION OF THE CONTRIBUTION OF THE CONTRIBUTIO	TREFATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSSIS WITH DSYCHOLIC YEACTION. Internature of injury in Part I or Part II of item 18.) LILL LAND CE OF INJURY (Home, farm, 20t. (City or town) ory, street, office bidg., atc.) Sylvantic Correlation Inquiry V, indicate Inspection Inquiry V, indicate	PERFORMED? YES NO (State) and in my opinion DATE SIGNED 8/28/61.
MEDICAL	PART J OTHER S.GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO C. B. J. ASSOC. WITH CEPEDRAL ARTERIOSCIEPT 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING OF CAUSE OF DEATH. 200. TIME OF INJURY Hour a.m. S. J.	TREFATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSSIS WITH DSYCHOLIC reaction. Internature of injury in Part I or Part II of item 18.) LILL LAND CE OF INJURY (Home, farm, 20t. (City or town) ory, street, office bidg., atc.) Support Constitution of the part II of item 18.) LILL LAND CE OF INJURY (Home, farm, 20t. (City or town) ory, street, office bidg., atc.) Support County of County of County (County) COUNTY OF INJURY (Home, farm, 20t. (City or town) or county)	YES NO (Steta) And in my opinion DATE SIGNED
WEDICAL	C. B. S. assoc. with cerebral arteriosclere 206. External cause was primary or contributing to peath but no cerebral arteriosclere 206. External cause was primary or contributing of cause of death. 206. Time of injury month, Dey, Yeer 20d, injury occurred 20e plants of work 20d, injury occurred 20d	TRELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSSIS WITH PSYCHOTIC REACTION. Inter nature of injury in Part I or Part II of item 1B.) CE OF INJURY (Home, form, 20t. (City or town) ory, street, office bidge, atc.) Square Constitution of the control	PERFORMED? YES NO (Steta) And in my opinion DATE SIGNED 8/28/61. (State)
WEDICAL	C. B. S. assoc. with cerebral arteriosclere 206. External cause was PRIMARY or CONTRIBUTING Death BUT NO CAUSE OF DEATH. 206. TIME OF INJURY CAUSE OF DEATH. 207. TIME OF INJURY CAUSE OF DEATH. 208. Time OF INJURY CAUSE OF DEATH. 209. DESCRIBE HOW INJURY OCCURED. (B. A. C.	TRELATED TO THE TERMINAL D.SEASE CONDITION GIVEN IN PART OSIS WITH DSYCHOLIC reaction. Internature of Injury in Part I or Part II of Item 1B.) LILL L. L	(State) PATE SIGNED AND STATE AND STATE (State) AND STATE (State) AND STATE (State) (State) AND STATE (State) AND STATE (State) (State) AND STATE (State) (State)



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the funeral director, should be filed with ofter death. Page 4

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pup filled Pages 1 TO HOSPITAL OR ATTENDING PLATICIEN: The low requires that the death contribute be exempted with may be the death control of the property of FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completeness a shauld be detoched for use as the burial-transit permit. Then please remove carbon papers, the State Board of Health prior to burial, cremotion, or removal, and in any event, within 72 hours after.

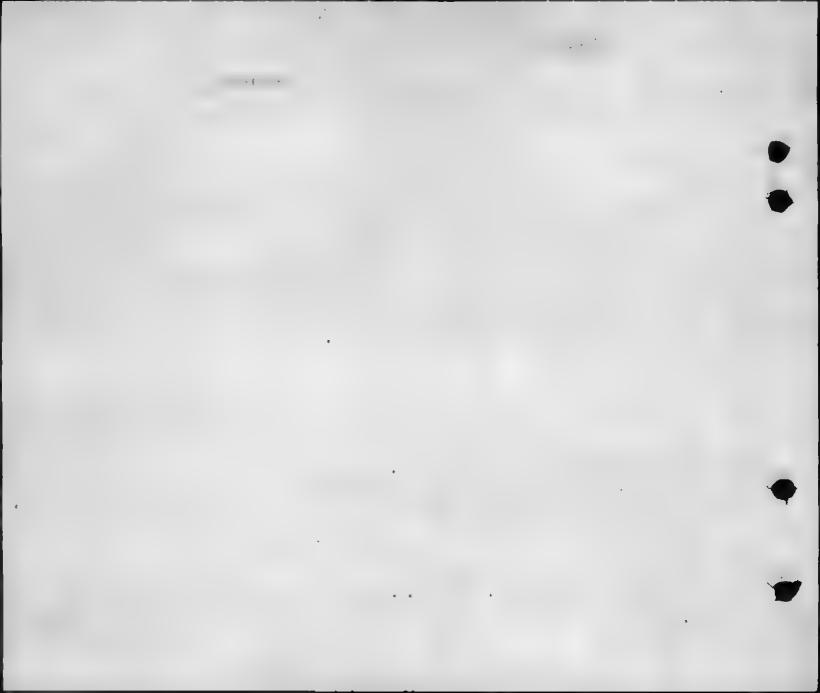
VR A15 (4) 15M 9/59

o. COUNTY			o. STATE		COUNTY	a perore domission)
Carroll		MARYLAND	Maryl			to.City
b. CITY OR TOWN (If outside corporate RURAL and give nearest town)	limits, write	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (IF o	outside corporate lim	its, write RURAL and gi	ive nearest town)
Sykesville		10mos.5days	Baltim	ore		
d. NAME OF HOSPITAL (If not in hospite OR INSTITUTION	ol, give street	oddress)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
Springfield State	Hospi	tal	2050 E	.Fayette	St.	YES NO TO
3 NAME OF DECEASED	First	Middle	Last	4. DATE OF	Month	Doy Year
(Type or print)	Rudolp	h	Junker	DEATH	August	23, 1961
5. SEX 6 COLOR OR RA	CE 7. MARI	RIED 🔼 NEVER MARRIED 🗌	B. DATE OF BIRTH	9 AGI	1 3 43 1 1 1	YEAR IF UNDER 24 HRS
Male White	WIDOW			1890	70 yrs. Months [Doys Hours Min
100 USUAL OCCUPATION (Give kind of wind during most of working life, even if rel	ork done 10b	KIND OF BUSINESS OR INDU	STRY 11 BIRTHPLACE (Stote	or foreign country)	12.CITIZ	ZEN OF WHAT COUNTRY?
during most of working life, even if rel Printing plant	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	Baltim	ore, Md	U.	.S.A.
13. FATHER'S NAME			14 MOTHER'S MAIDEN N	NAME		
Rudolph Junker			- Mill	er		
15 WAS DECEASED EVER IN U.S. ARMED IYOS, no or unknown) [III yes, give wor or date		SOCIAL SECURITY NO 17 1	NFORMANT		Address	
No -	5	218-12-7634-4	Springfield !	Hospital	Records	
18. CAUSE OF DEATH [Enter only on	e couse per li	ine for (o), (b), and (c).]				INTERVAL BETWEEN
PART I, DEATH WAS CAUSED I	Y: Go	ngrene of legs				Weeks
IMMEDIATE CAUS	E TO	HELENG OF TEES				110020
Conditions, if ony, which)	Ge	neralized arte	miosclerosis			Years.
gove rise to immediate	(6)	TOT WILLDOW GIVE				TCG15
lying couse lost.	10					
	(c)	CONTRIBLTING TO DEATH BUT	T NOT DELATED TO THE TERM	INIAI DISEASE CONI	OUTION GIVEN IN PART	TIME TO WAS ALITOPSY
Schizophrenic rea	ction,	paranoid type	•	INAE DISEASE COIN	2 TION ON EN DATAM	PERFORMED? YES NO
Part II OTHER SIGNIFICANT OF SCHIZOPHRENIC TEST Schizophrenic results 200 ACCIDENT WAS UNDERLYING DO CONTRIBUTING DO CAUSE OF DEAL OF CONTRIBUTING DO CAUSE OF CONTRIBUTING DO	ATH I	SCRIBE HOW INJURY OCCURRI	ED. (Enter noture of injury in	Part I or Port II of i	rem 18.)	
	Year 20d (NJURY OCCURRED 20e. PI	ACE OF INJURY (Home, farm	n, 20f. (City or tow	rn\ {C	County) (Stote)
Hour o, m,	19 While	Not while fo	octory, street, office bldg., etc			
21 I certify that (I) (this hasp	ital) attend	ded the deceased fram.	October 18, 19	60 to Augu	st 23, 196	L, that (I) (we) last
saw the deceased alive an						
220 SIGNATURE	1 12 -	1				22b. DATE
Country a	21 C.	mpo.	M.D PHYS. DI	ED. STA	ff 🗗	8/23/61
PACE PHYSIC AN'S	other .		22d. ADDRESS			
Not (Type) Agustin	delCam	po, M.D.	Springfie	ld Hospit	al,Sykesvi	lle,Md.
23a. BURIAL CREMATION 23b DATE THE		23c. NAME OF CEMETERY			City, town, or county)	(Stote)
BURTAIPecify) 8-26-0	51	New Cathedr	al Cemetery	Balti	more	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		D BY REGISTRAR	256 REGISTRAR'S SIG	NATURE
Wm.Cook, Inc., 12	17 St.	Paul Street	DATE	UG 2 8 '61	Circhus &	House

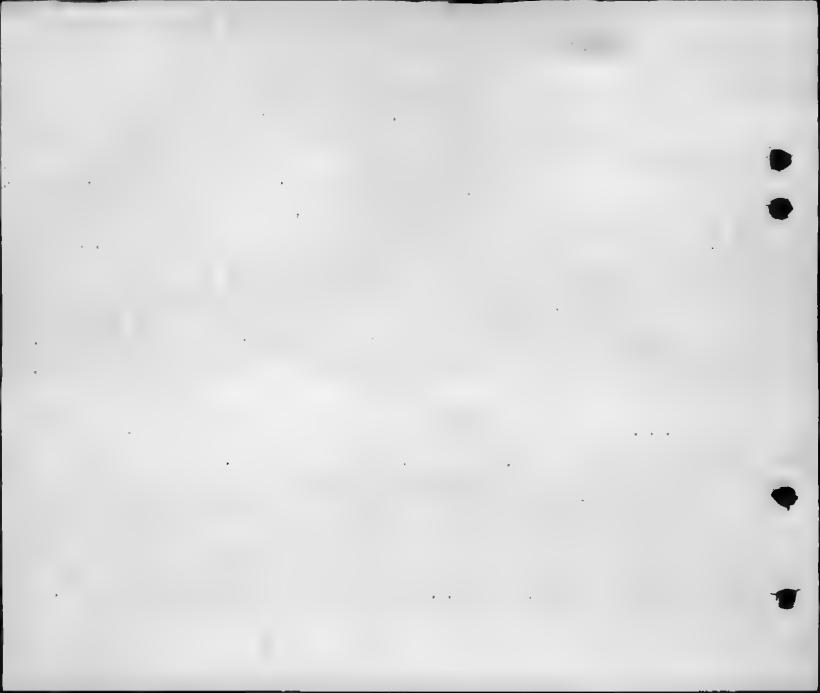


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FUN STATE CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institutions Residence before admission) e. COUNTY necessary, actor, Page files. * a. STATE b. COUNTY Carroll. Vary Land MARYLAND Carroll b CITY OR TOWN (if outside corporate I mits. L. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) director. wrda RURAL and give negrast lown) your Miller's Station Carrollton d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addrass) for d. STREET ADDRESS a. IS RESIDENCE ON A FARM? retained ne State B YES 🦳 NO 🏋 NAME OF First 4. DATE Last Month Year DECEASED OF (Type or print) BEVERLY KOCHER DEATH 2, and 2 with and 2 with 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (in years | IF UNDER 1 YEAR) IF UNDER 24 HRS. last birthday) Months! Days Hours Female White WIDOWED DIVORCED 10a. USUAL OCCUPAT ON (Give kind of work 106. KIND OF BUSINESS OR INDUSTIN 12. CITIZEN OF WHAT COUNTRY? done during most of working I fa, aven if refired) PM3. Pa pages 1 14. MOTHER'S MAID! 16. SOCIAL SECURITY NO. ARMED FORCES? (Yes, no, or unkows) ((fixes give war or datas of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY Gunshot Wound of IMMEDIATE CAUSE (a) Office DUE TO burial Conditions if any, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDIT ON GIVEN IN PART 1(a)) 19, WAS AUTOPSY CERTIFICATION Medical L. should be u PERFORMED? NO 1 20s. EXTERNAL CAUSE WAS PRIMARY To or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of Itam 18.) CAUSE OF DEATH. Shot in head. Vriting 1 Chief A age 3 s 20c. TIME OF INJURY Month, Day, Yaar 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 1 20f. (City or town) (County) (State) Not While fectory, street, office bldg., atc.) While the 10 OL af work at work 3 prior Parked auto Miller's Station Carroll OH; 0 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opin on be forwarded I death resulted from. Natural causes Accident Suicide Homicide X Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER TO should be for DATE SIGNED designat SIGNATURE DEPUTY MEDICAL EXAMINER 8/6/61 **EXAMINER'S** Charles Petty. M.D. NAME (Type) Address (Street, city, town, or county) DE 228. BURIAL, CREMATION, 226. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or country) MOVAL (Space 240 g 24s. REC'D BY VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATI MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased I vad, if Institution: Residence before admission) If elay is necessary, other innerest director. Page or retained for your files, the State Board of Health, a. COUNTY Balto. City a. STATE Carroll MARYLAND Maryland Datoo Otoy
c. C.Ty Ok 10WN (if outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, E. LENGTH OF STAY IN 16 write RURAL and give neerest town) Sykesville 2vrs.llmos.3dvs Baltimore 2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Springfield State Hospital YES TO NO THE Market Place 3. NAME OF 4. DATE M.ddla Month DECEASED the (Type or print) DEATH Joseph Lex. Jr. August 19 61 2 with 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF LINDER 24 HRS last birthday) Hours Male White WIDOWED [DIVORCED August 27, 1904 56 23 and 727 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (Stelle or foreign country) 12. CITIZEN OF WHAT COUNTRY? Page I done during most of working life, even if retired) U.S.A. Laborer Brewery Pennsvlvania withix P.M.3. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Joseph Lex Theresa Woodsanger 15. WAS DECEASED EYER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) ([If yas give wer or detas of service) in Dencil in Item 1 Office along with burial-transit perm Springfield Hospital Records 18. CAUSE OF DEATH Enter only one cause par line for (a), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Pulmonary Embolism, source unknown. Minutes. DUE TO (b) Subdural hematoma due to skull fracture days. "pending" geve rise to immadiate cause Medical Examiner's should be used as a DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19. WAS AUTOPSY CERTIFICATION PERFORMED? C.B.S. associated with Convulsive Disorder without qualifying phrase. the word NO F 2De. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW INJURY OCCURED, (Entar natura of injury in Part I or Part II of item 18.) PRIMARY IT or CONTRIBUTING X Pt. had seizure. struck head on floor. CAUSE OF DEATH. xecute the certificate, writing I be forwarded to the Chief / ERAL DIRECTOR: Page 3 s 20e. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, ; 20f. (City or lown) (County) (State) factory, street, office bldg., atc.) Carroll Maryland Sykesville al work - al work X Hospital prior 21. I certify that I took charge of the remains described above, held an Autopsy 🔀 . Inspection 🔀 . Inquiry 🛣 . and in my opinion death resulted from Natural causes Accident TX Suicide Homicide | Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL designated ASSISTANT MEDICAL EXAMINER DATE SIGNED should be for SIGNATURE 8-17-61 M DEPUTY MEDICAL EXAMINERSE EXAMINER'S Westminster. Md. James T. Marsh. NAME (Typa) M.D. Address (Streat, city, town, or county) 228 BURIAN CREMATION 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (Stale) REMOVAL ISPORTY g 40 g 24a. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR ADDRESS VS. A15ME Reese DATE AUG 2 2 '61 5M 7/59 arthur & House



. PRESTON STREET, BALTIMORE 1, MARYLAND Division of STATISTICAL RESEARCH **FOR STATE** QROMEDICAL EXAMINER'S L. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before edmission) a. COUNTY. MARYLAND b. CITY OR TOWN (if outside corporate limits C. LENGTH OF STAY IN 16 ral director. ON A FARM? YES NO DECEASED (Type or print) DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 2 3 yrs. Months 12. CITIZEN OF WHAT COUNTRY? pages with form PM3. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORM permit. (Yes, no. or unkown) | (If yes give wer or detes of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN Office along v ONSET AND DEATH PART I. DEATH WAS CAUSED BY. DISLOCATIO MMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate cause DUE TO (a), stelling the underlying ceuse lest. cremation, PART I., OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6); 19, WAS ALTOPSY PERFORMED? 8 CERTIFIC plnous 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter natura of in ury in Part II or Part II of Item 18.) tring the PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. Chief forwarded to the Chief 20d, INJURY OCCURRED I, 20e, PLACE OF INJURY (Home, ferm, 1 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year (County) (State) fectory, street, office bldg., etc.) Not While prior 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Inquiry and in my opinion agent, death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER [ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURAL FUNERAL. DEPUTY MEDICAL EXAMINER EXAMINER'S should Address (Street, city, town, or county) 22d. LOCATION (City, town, or country) DATE THEREOF NAME OF CEMETERY OR CREMATORY (State) Ä OH Z.40 ò VS. AISME Chilmy S. Kings 5M 7/59



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 8990 funeral within 24 hours after PLACE OF DEATH 15

1 2. USUAL RESIDENCE (Where decessed lived, if institution: Residence before edmission)

a. COUNTY		e, STATE	b. C0	DUNTY	/
Carroll	MARYLAND	Marvla	_	Montgome	ary Go. V
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16		If outside corporete limits,	write RURAL and o	(Ive hearest town)
Sykesville	3mos.20dys.	Silver	Spring	1, 1,	A phone -
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospit	al, giva street address)	d. STREET ADDRESS			e. IS RESIDENCE
Cominacial Chaba II	1.9	10500	Ones address to an in		ON A FARM?
Springfield State Hospi	.Tal Middle	10509	Sweetbriar P		YES NO P
DECEASED	Muddle	Fest	OF	onin i	Dey Tear
(Type or print) Meropi		Mandalou	DEATH Au	gust 2	2 1961
5. SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED 8.	DATE OF BIRTH	9. AGE (In ye	ers IF UNDER 1 YE	AR IF UNDER 24 HRS.
Female White WIDOWED		lataban 1 1	don lest birthde	14101111111	ys Hours Min.
	D OF BUSINESS OR INDUSTRY	october 1, 1	.892 68 yrs	j i	N OF WHAT COUNTRY?
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Dressmaker & Landlady	-	Greece		U_8	S.A
13. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME		
Annatana a Ammaldan		36 4			
Anestoras Arralios 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SC	CHAL SECTIBITY NO. 1 17 TB	Mary As	K1618		
(Yes, no, or unkown) (Hyesgivawarordalesofsarvice)	JOHN SECONTE NO. 17. 11	ar Outlitz#Ar	V00	1.672	
No	- St	ringfield H	ospital Reco	rds	
18. CRUSE OF DEATH (Enter only one ceuse per line	for (a), (b), end (c).	3			INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ronal	Failura				Days
666	* (1-1 <u>104 C</u>		year a		- Pays
DUE TO					
Conditions, if any, which (b) Pyolo	nephrit <u>i</u> s				Weeks
geve rise to immediate cause (a), stating the underlying DUE TO					
ceusa last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTI	BUTING TO DEATH BUT NOT	RELATED TO THE TERMI	NAL DISEASE CONDITION	GIVEN IN PART II	all 19. WAS AUTOPSY
Arteriosclerotic cardiova			Mellitus.		PERFORMED?
0					TES NO PE
Arteriosclerotic cardiova 200. Accident WAS UNDERLYING COR CONTRIBUTING CAUGE OF DEATH OR CONTRIBUTING CAUGE OF DEATH OF THER NOTIFY MEDICAL EXAMINER)	IBE HOW INJURY OCCURED.	(Enter neture of injury in	Pert I or Pert II of item 18.)		
U (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year 20d. IN Hour e.m. While of work		E Of INJURY (Home, ferr		(County	(State)
Hour e.m. While		ry, streel, office bldg., etc)		
			4-		
21. I certify that (I) (this hospital) attende	d the deceased from	4-12-	19.61 to	3 2, 196]	ا, that (I) (we) last
saw the deceased alive on	19 61 , and that	death occured at $oldsymbol{1}$	2:05 from the caus	es and on the	date stated above.
220 SIGNATURE		1			22b. DATE
I K TEULL RYKLEV	Tot M.C	Partice III	MED. STAFF DIRECTOR PHYS. [X.	8-2-6L
226. PHYSICIAN'S	/ ma	22d. ADDRESS			
NAME (Type)	V N		7 7 77 7	0.1	2 202 6
Julian Radzyk	ewycz, M.D.		ld Hospital,	7.07	/
236. SHRIAL, CREMATION, 235 DATE THEREOF	230. NAME OF CEMETERY O	R CHEMATORY	23d. LOCATION (City	joy n ar county)	1. State in
Durial Juguet 4-61	Hearque fra	changlon.	1 ragge	and - 12	mealor 116
24 FUNERAL DIRECTOR'S SUGNATURE	MODRESS IT II	250, RE	C'D BY REGISTRAR 256.	REGISTRAR'S SIG	NATURE
Karker Valtages 25	- Derroll at	11.74	AUG 3 '61	2 1 0	w.
TOWN WO NELLECT AND	/	DATE	1011 0 01 1	arthur &	Trace

death. 1996 4 may be retain, by the hospital or attending physician.

TO FUNERAL DIRECTOR: Affer this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be defached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate PHYSICIAN: TO HC death. **VR A15 (4)**

15M 9/60



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1	PLACE OF DEATH O. COUNTY Car	roll			MARYLAND	O STATE	NCE (Where deceasing Land	ed lived. If institut b. COUNTY		before odn	lission)
F	b. CITY OR TOWN (IF RURAL and give ned ural—Syke:	rest tawn)	ts, write	c. LENGTH OF	stay in 16	I† _	WN (If outside corp	orate limits, write f	RURAL and giv	e neorest to	iwn)
	d NAME OF HOSPITA OR INSTITUTION pringfield	L (If not in hospital, g		oddress)	ZIL (# Gen gday to	d. STREET ADD		- 1	×	ON	RESIDENCE A FARM?
3.	NAME OF DECEASED (Type or print)	Fir Ha	llie		Niddle B.	McGraw	4. DATE OF DEATH	Moi 8	nth	10 Day	Year 19 61
15	sex female	6 COLOR OR RACE	7 MAR	RRIED NEVER A	AARRIED X	8. DATE OF BIRTH	,	9. AGE (In years lost birthdoy) 86? yrs.		YEAR IF UN	
_	USUAL OCCUPATION during most of working most of working none	N (Give kind af work ng life, even if retired	done 10b	. KIND OF BUSIN	ESS OR INDU		E (State ar foreign				T COUNTRY
	Jack McGr	aw				Kratz					
	WAS DECEASED EVER			. SOCIAL SECURIT	Y NO 17 1	NFORMANT		Add	Iress		
	s, no. or unknown) (li	yes, give war or dates of s	arvica)		Spr	ringfield	Hospital	records,	Sykesv	rille,	Md.
CATION	Conditions, if an gove rise to im cause (a), stating the lying couse last. PART I: OTHE	me di ate ne <u>under-</u> DUE TO (c ER SIGNIFICANT CON	di	CONTRIBUTING 1	oticemi	a and mul			VEN IN PART I	(o) 19 WA	FORMED?
CERTIFICA	200 ACCIDENT WAS OR CONTRIBUTING I	enic React underlying Cause of DEATH MEDICAL EXAMINER)				D. (Enter noture of i	njury in Part i or Pa	ort II of item IB.)		YES	<u> </u>
MEDICAL	20c. TIME OF INJURY Hour o m. p. m.	Manth, Doy, Ye	While	INJURY OCCURRE Not while ork at wark	D 20e. PL	ACE OF INJURY (Ho clory, street, office b	me, farm, 20f. (Ci	ty or fawn)	(Co	unity)	(State
	saw the decease 220 SIGNATURE 220 PHYSICIAN'S	h	/10/		and that	11/19/ death accurred ATTENDING PHYS 22d ADDRESS	MED. DIRECTOR D Springs	STAFF	te Hos	date state	(we) lasted above 22b DATE / 11/6.
23	BLRIAL, CREMATION REMOVAL ISPECIAL BUNERAL DIRECTOR'S	Ceux 13-	196	23c NAME OF	COMETERY O	U. CELL	23d LOCA	ATION (City, Jown,	ar county) AC	Md-	itate)

TO HOSP OR ATTENDING COLON: The faw requires that the death certificate be executed by now be completely by the haspital attending physician.

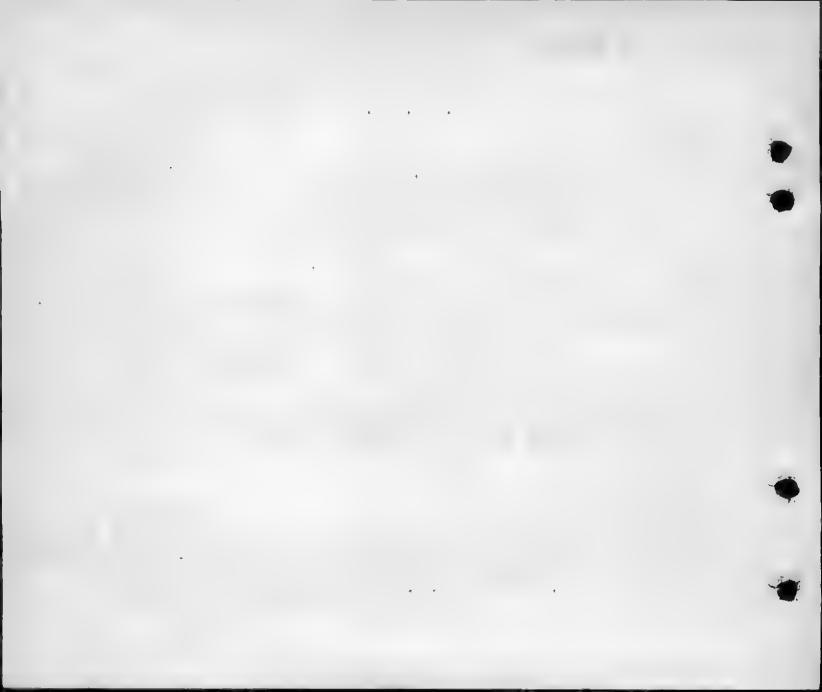
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached far use as the burial-transit permit. Then please remove carban papers. Pages the State Board of Health priar to burial, crematian, or remaval, and in any event, within 72 haurs after death.

VR A15 (4) 1SM 9/59

s after death Page 4

y the funeral directar, 2 shauld be filed with

y filled Pages 1



DIVISION OF STATISTICAL RESEARCH AND RECO STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH . PLACE OF DEAT 2. USUAL RESIDENCE (Where deceased lived, If institution; Rasidenca before edmission) a. COUNTY by the and 2 death. Balto. City Carroll MARYLAND Maryland b. CITY OR TOWN (if oulside corporate limits, E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give nearest town) Sykesville 2 mos. 8 da d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2 mos. 8 days Baltimore 2 d. STREET ADDRESS . IS RESIDENCE 72 hours ON A FARM? Springfield State Hospital YES NO 909 Wilmet Court NAME OF 4. DATE DECEASED OF (Type or print) DEATH 19 61 Babette August C Menne 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X with IF UNDER 24 HRS. 8. DATE OF BRITH lest birthdey) Months Days Female White WIDOWED [DIVORCED 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11, BIR (PLACE (County & Stere or fore an country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, even if retired) U.S.A. Insurance Stenographer Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Herman Menne Babette Munker 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or detes of service) Springfield Hospital Records No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Years Arteriosclerotic heart disease due to IMMEDIATE CAUSE (a) arteriosclerosis. DUE TO Chronic nephrosclerosis due to arteriosclerosis. Conditions, if any, which geve rise to immediate cause **DUE TO** (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? C.B.S. with cerebral arteriosclerosis with psychotic reaction. YES THE NO 20s. ACCIDENT WAS UNDERLYING | | 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part 1 or Part II of Item 18.)
OR CONTRIBUTING | CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, ' 20f. (City or town) (State) factory, streat, office bldg., etc.) While _Not While Hour a.m. et work at work 4 may be retained.

I. DIRECTOR: As 3 should be detent.

the State Dept. o 19.61, and that death occurred at 300, Promothe causes and on the date stated above. saw the deceased alive on 22b. DATE 22a. SIGNATURE ATTENDING 8-9-61 PHYS. PHYS. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS Springfield Hospital, Sykesville, Md. NAME (Type) Julian Radzykewycz, M.D. 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 123c. NAME OF CEMETERY OR CREMATORY (Steta) REMOVAL (Specify) 2 4 2 BURIAL Woodlawn Cemetery Woodlawn Md 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS VR A15 (4) century S. Krana Wm. Cook, Inc., 1217 St. Paul Street, Zone 2

Pages

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LARYLAND STATE DEPARTMENT OF HEALTH



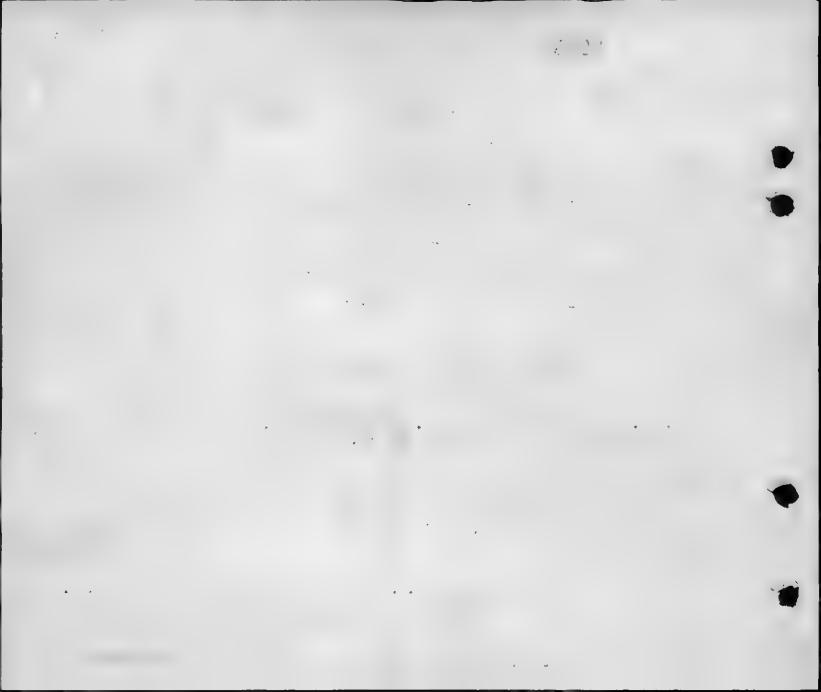
DIVISION OF STATISTICAL RESEARCH AND RECORDS **PRESTON STREET, BALTIMORE 1, MARYL** CERTIFICATE OF DEATH funeral plnous I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased I ved, If institution, Residence before admission) a. COUNTY a. STATE b. COUNTY Garroll 22 MARYLAND Marvland Frederick by than b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outs'de corporete limits, write RURAL and give neerest town) write RURAL and give nearest town) Sykesville .E ₩ 20 days Frederick after Pages Filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) d. STREET ADDRESS IS RESIDENCE hours ON A FARM? Springfield State Hospital YES NO TE completely papers. NAME OF M ddle 4. DATE Yes DECEASED OF 19 67 (Type or print) Emory Morgan August DEATH within carbon 16 COLOR OR RACE 7. MARRIED NEVER MARRIED AGE [In years | IF UNDER 1 YEAR 8. DATE OF BIRTH IF UNDER 24 HRS. last birthday) Months Days Hours Male Unknown WIDOWED 1 DIVORCED event, physician геттоме 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Unknown Unknown Marvland 13. FATHER'S NAME 14. MOTHER'S MAJDEN NAME please ≘. Then please Napoleon Morgan and Mary Bruchev 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO : 17. INFORMANT Addrass ioval, (Yes, no, or unkown) | (Ifyes give wer or dates of service) physician. No Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one cause per I ne for (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Senticemia IMMEDIATE CAUSE (e) Days has been signed DUE TO Week Gangrene of right foot Conditions, if any, which gave rise to immediate cause DUE TO (a), slating the underlying couse lest. C.B.S. with senile brain disease. Diabetes Mellitus. NO K **USB** prior CERTIFICA Arteriosclerotic cardiovascular disease.

a. ACCIDENT WAS UNDERLYING [] | 20b. DESCRIBE HOW INJURY OCCURED (Enter neture of injury in Part Lor Part Lor Jean 18.) 200. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, term, 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) While Not While Hour a.m. et work at work D.m. may be reta. DIRECTOR: 21. I certify that (I) (this hospital) attended the deceased from July 13, 19 61 to August 3, 19 61 that (1) (we) last August 2. 19.61, and that death occured at 12.425AM the causes and on the date stated above. saw the deceased alive on... 22b. DATE SEGNATURE 61 SIGNED ATTENDING PHYS. 2 DIRECTOR PHYS. at ge 4 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Julian Radcykowycz, M.D. Springfield Hospital, Sykesville, Md. director, p 239 SURFAL CREMATION, | 236 DATE THEREOF 23d. LOCATION (Gity, fown or county) (State) REMOVAL (Specify) 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 DANUG Circling S. Thrank

attending

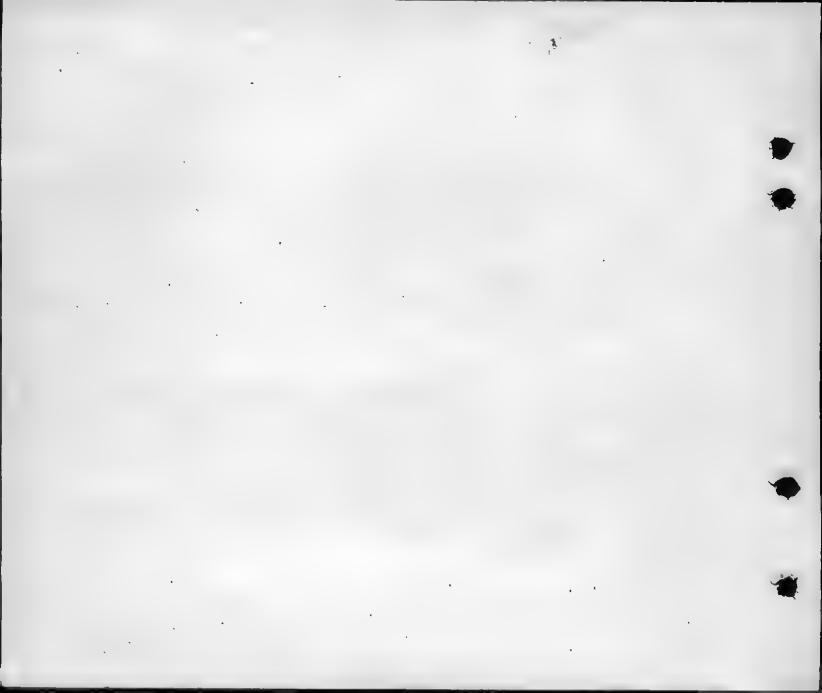
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MARYLAND STATE DEPARTMENT OF HEALTH



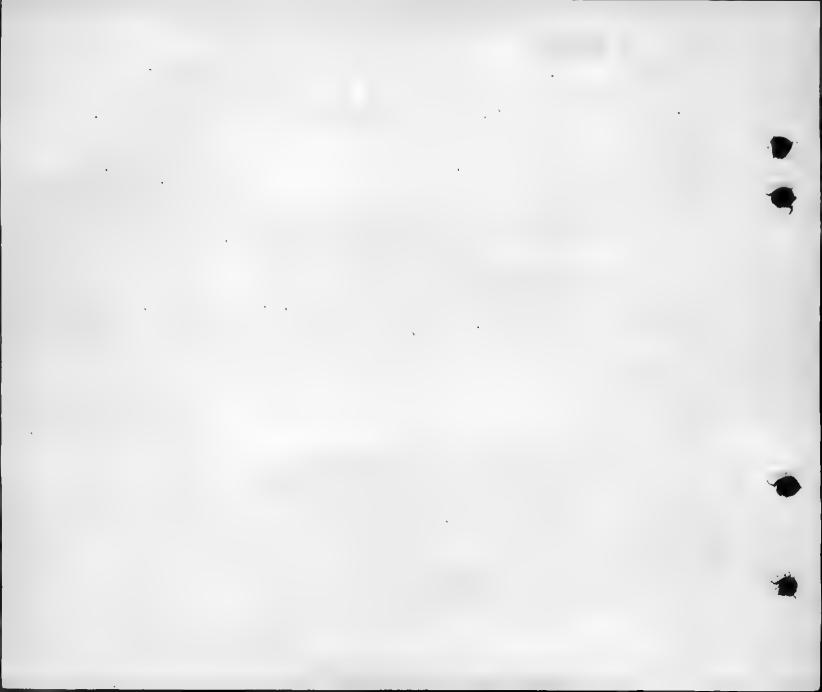
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Page	De la			ACCOUNTY DELL'ACTION MARYLAND 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) OFFICE (Where deceased lived. If institution: Residence before admission) OFFICE (Where deceased lived. If institution: Residence before admission) OFFICE (Where deceased lived. If institution: Residence before admission)
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IAN: 1 lending	the bu		L CERT F	20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.)
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NG spire	d far			21 I certify that (1) (this haspital) attended the deceased fram 2 -17 1961 to 8-17 1961, that (1) (we) to
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d by th	be deta of Hea	1		220 S GNATURE IN FORMAL M.D. PHYS MED DIRECTOR STAFF 8/19/6 SIGNE
o le	shauld Baard	1		22c. PHYSICIAN'S NAME (Type) WH FOARD MD 22d. ADDRESS MAME (Type) WH FOARD MD
OSP P be	State		23a	BURIAL, CREMATION, 23b, DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town, or county) (Stote)
O E C	Pag the	.2	10	Quint any 10-6/ Hampacad sellate to Ma
VP A15	in V	AY !	24	FINERAL DIRECTOR'S SIGNATURE ADDRESS
1SM 9/	59	18	1	1 PIONI-ELINE Hacipala VILO DATE

ofter death. Page 4



CERTIFICATE OF DEATH I director, filed with PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission o COUNTY H b. COUNTY MARYLAND Carroll Marvland Balto.City b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 8vrs.8mos.29davs Sykesville Baltimore 23 d. NAME OF HOSPITAL (If not in haspital, give street address) IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? Springfield State Hospital 7 N. Carev Street YES NO IV NAME OF Middle 4, DATE Month OF DEATH Naylor (Type or print) Thomas August George 19 5 SEX 6 COLOR OR RACE 7 MARRIED TO NEVER MARRIED TE B. DATE OF BIRTH IF UNDER 1 YEAR! IF UNDER 24 HRS 9. AGE (In years lost birthdoy) Months Days May 9. 1883 Male White DIVORCED [* WIDOWED | 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? U.S.A. Maryland Street cleaner 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Bertie Steg Thomas Navlor 15, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT Address attending Νn Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (6) Cancer of the lung Months **DUE TO** Conditions, if ony, which gove rise to immediate DUE TO cause (a), slating the underlying cause last. C.B.S. assoc. with convulsive disorder, associated with psychotic 19. Was autopsy YES 🔲 NO 🔀 reaction. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20d. INTURY OCCURRED 20f. (City or town) (Stote) (County) Hour a.m. foctory, street, office bldg., etc.) While Nat while at wark at wark 21. I certify that (1) (this hospital) attended the deceased from Dec. 1. 19 52 to August 30, 19 61 that (1) (we) last saw the deceased office an August 30, 1961, and that death accurred at 2:30PMom the causes and on the date stoted above. 22b DATE 22o 5 GNATURE ATTENDING PHYS STAFF PO M.D. DIRECTOR 22c PHYSICIAN'S NAME (Type) 22d. ADDRESS Agustin delCampo, M.D. Springfield Hospital, Sykesville, Md. 230 BURIAL CREMATION. 23h DATE THEREOF 23c NAME OF CEMETERY, OR CREMATORY 23d LOCATION (City, town, or sounty) y (Stote) 24. FUHERAL-DIRECTOR'S SIGNATUR 256 REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR C Thung & Kings VR A15 (4) 15M 9/59





	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	
£	8997 CERTIFICATE OF DEATH Reg Dist. No.	08388
V	1. PLAIRE OF THEATH O. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before o. STATE b. COUNTY D. COUNTY MARYLAND	re odmission)
13	b. LITY OR TOWN (If outside corporate limits, write RURAL and give near RURAL and give pearest fown)	srest town)
	d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION CONTROL OF THE STREET ADDRESS WHITE THE STR	e. IS RESIDENCE ON A FARM? YES TO NO TO
	3/NAME OF DECEASED (Type or print) Plur rarst: mary with 10st 1 Date Month Do De Death (Type or print)	y Year
		IF UNDER 24 HRS. Hours Min
		WHAT COUNTRY?
	13. FATHER'S NAME David S. 常情報報情報 Plunkert Laura ?	3
A DOOR N	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT (16 yes, give wor or doles of service) 213-63-6448 Loretta A. Freburger	
	18. CAUSE OF DEATH [Enter only one couse per time for (o), (b), and (c).] PART I, DEATH WAS CAUSED BY:	ERVAL SETWEEN
100 V	DUE TO	D. day
5	Conditions, if ony, which gove rise to immediate couse (a), stating the under-lying couse lost	Rome
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(o)	9 WAS AJTOPSY PERFORMED? YES NO
1	200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	130 1400
	20c TIME OF INJURY Month, Doy, Year 20d, INJURY OCCURRED PLACE OF INJURY Home, form, 20f. (City or town) (County) Hour o. m While Not bise	(Stole)
	21. I certify that I attended the deceased from S25 79 & 1, to 5-3/-194/that I last sov	v the deceased
	olive on	e stated above. DATE SIGNED
	SIGNATURE M.D. SIGNATURE	nq
eg se	PHYSICIAN'S NAME (Type) 70. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, fown, or county) REMOVAL (Specify) REMOVAL (Specify)	(Stote)
2	23. FUNERAL DIRECTOR'S, SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	RE
)(Howard H. Hubbard 4107 Wilkens Ave. Date 27 5 '61 Cathy & Kin	



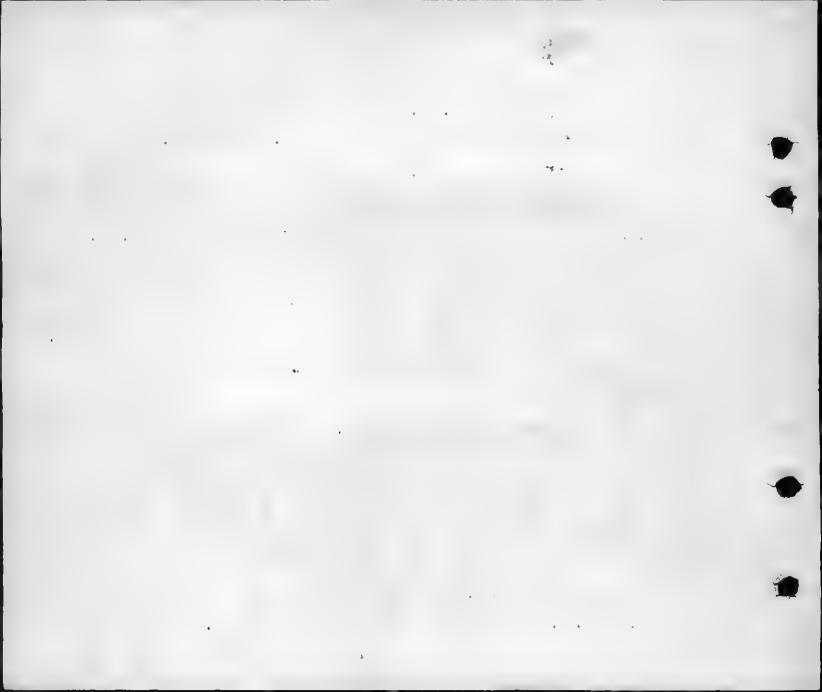
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9000 CERTIFICATE OF DEATH 08989

24 hz offer death. Page 4	5	ed in by the funeral director,	1 and 2 should be filled with	(U
TO HOSPI, OR ATTENDING P. ICIAN: The law requires that the death certificate be executed to 24 hard, ofter death. Page 4	attending physician.	TO FUNERAL DIRECTOR: After this Serviticate has been signed by the ottending physician and complexity filled in Dy the funeral director.	page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with	the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 haurs after death.	(
TO HOSPU OR ATTENDING PA	may be uned by the haspital attending physician.	TO FUNERAL DIRECTOR: After this	page 3 should be detached for un	the State Board of Health prior to	

VR A15 (4) 15M 9/59

	6339		CERTITI	9711	OI PEAIII				
1. PLACE OF DEATH	*			2.	USUAL RESIDENCE (W	here deceased			before admission)
o. COUNTY	Carroll		MARYLA	DUN	Maryla Maryla	nd	b. COUNTY		L *
b CITY OR TOWN RURAL and give	(If outs de carporate lim	ils, write	c. LENGTH OF STAY IN	116	c CITY OR TOWN (IF	autside carpara	ate limits, write l	RURAL and go	ve nearest town)
	- Sykesville	9	12yr.8mo.2	days	Baltim	ore Cit	t y	31	11-4
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in haspital, g	give street	address)		d. STREET ADDRESS				e. IS RESIDENCE
S	ringfield S	State	Hospital		715 M.	Henrie	etta St.		YES NO
3 NAME OF DECEASED	Fi	rsi	Middle		Łast	4. DATE OF	Mai		Day Year
(Type ar print)	Sarah		E.		PRIDHAM	DEATH	AUGU	ST	18 1961
S. SEX	6. COLOR OR RACE	7 MARI	RIED NEVER MARRIED	B. D	ATE OF BIRTH	5	AGE (In years		YEAR IF UNDER 24 H
Female	White	WIDOWI	ED 🔼 DIVORCED		4-1-1863		log birthday) 90%? yrs	Months	Days Haurs Min
10a. USUAL OCCUPAT	ION (Give kind of wark rking life, even if retired	done 10b	KIND OF BUSINESS OR	INDUSTRY		or fareign cau	intry)	1	EN OF WHAT COUNTE
H.W.		,			Maryland			U.S	.A.
13. FATHER'S NAME				1	4. MOTHER'S MAIDEN	NAME			
David Wy	ble				nknown				
(Yes. na, or unknown)	ER IN U. S ARMED FOR (If yes, give war or dates of t		SOCIAL SECURITY NO.	17, INFO			Add	iress	
No				Hos	pital Recor	ds			
	ATH [Enter anly one co	ouse per li	ne far (a), (b), and (c)-]						INTERVAL BETWEEN
PART I. DE	ATH WAS CAUSED BY: IMMEDIATE CAUSE (c	Hea	rt Failure						2 wks.
147	DUE TO								
Conditions, if	· · · · · · · · · · · · · · · · · · ·	Art	eriosclerot	ic He	art Disease	3			Years
gave rise ta couse (a), stating	> DUE TO								
lying couse last		-)							<u> </u>
1 = 1			CONTRIBUTING TO DEAT	_		IINAL DISEASE	CONDITION GI	VEN IN PART	1(a) 19 WAS AUTOP PERFORMED?
	le psychosi	s, si	mple deteri	orati	on.				YES NO
200 ACCIDENT WOR CONTRIBUTING	20c ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAJSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
30c. TIME OF INJU	IRY Month, Day, Ye		NJURY OCCURRED 2		OF INJURY Hame, fare		ar tawn)	(Co	ounty) (Sto
20c. TIME OF INJU	19	While at war	Nat while	raciary	r, street, affice bldg , et	c 1			
	ot 🕅 (this hospita	1) attend	ded the deceased f	rom	11-26	48 10 1	8-18	1961	, that A (we) la
	ased alive on 8.				th occurred of3:3	10			
22a. SIGNATURE		7	A A	1101 000	Discorded diggs	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	110 000103 01	011 1110	22b, DATE
	751	1 1	Eller 11	∧ M.D	ATTENDING A	AED.	STAFF PHYS		8-18-61
22c PHYSICIAN'S NAME (Type)			·		22d. ADDRESS				
(Type)	Ilse Kam	n. M.	_D		Sykesvil	le, Ma	ryland		
230 BURIAL, CREMATI	a l	OF.	23c NAME OF CEMET	ERY OR C	REMATORY	23d. LOCATI	ON (City, tawn,	ar caunty)	(State)
MOVA Specif	8.23.61		Meadowrid	ge	Mem	Bato M	ld.		
24, FUNERAL DIRECTO		٨	ADDRESS			D BY REGISTR		ISTRAR'S SIG	NATURE
McCully	130 E Fort	Ave	Balto 39	Md∙	DATE	UG 2 2 '6	51 2	Cathing of	2 -
to-			-						/ Hatte



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MARYLAND STATE DEPARTMENT OF HEALTH

8999 CERTIFICATE OF DEATH	08990
1 PLACE OF DEATH o COUNTY County MARYLAND 2 USUAL RESIDENCE (Where deceased lived finistitution: Residence before on STATE of COUNTY) County Cou	rell_
b. CITY OR TOWN (If outside corporate limits, write RURAL and give ne RURAL and give nearest town) C	earest town)
OR INSTITUTION	YES NO
(Type or print) E1124 both SABANIA SANDRUCK DEATH august 6	196/
Female 6. COLOR OR RACE 7. MARRIED MEVER MARRIED B DATE OF BIRTH 9. AGE (In year) IFUNDER I YEAR White WIDOWED DIVORCED Qua 15-1881 9. AGE (In year) IFUNDER I YEAR Months Days	Hours Min.
Housewife York County, Pa W	S. A
Samuel Comboner Caroline Garbick	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (17 yor, give war or dates of service) 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address Address Address Address	rodon,
	TERVAL BETWEEN
Conditions of day, which; (b) Ortemorelenstic Candia Varcular Directe	5 yes -
gove rise to immediate couse (a), stoting the under: DUE TO Cerebral Hernowhorse	15 mbs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(0) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH UP CONTRIBUTION CAUSE OF DEA	19 WAS AUTOPSY PERFORMED? YES NO 12-
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour o. m. While Not while of work of work of work (County factory, street, affice bldg., etc.)	r) (Stote)
21. I certify that (I) (this haspital) attended the deceased fram aug 5 , 184, to aug 6 , 196/, to saw the deceased alive an aug 5 , 196/, and that death occurred at 0.3 B, fram the doubles and on the date	hat (we) last e stated abave.
226 SIGNATURE HT FOUND ATTENDING MED STAFF SI SI	6 6 SIGNED
122c PHYSICIANS NAME (Type) W. H. FOArd. M.D. 122d. ADDRESS WANCH PSTET, Ma	/
230 BLR AL, CREMATON 236 DATE THEREOF 23c NAME OF CEMETERY OR FREMATORY 23d (SCATION (City, town, or county)) PRINCIPLE OF CHARGE OF CEMETERY OR FREMATORY CHARGE O	(State)
ADDRESS TEAM 250 REGISTRAR 256 REGISTRAR 256 REGISTRAR'S S GNATH	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS. W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 9000 . PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution) Residence before admission) e. COUNTY **b.** COUNTY Carroll by the land 2 : death. MARYLAND Marvland Montgomery b. CITY OR TOWN (if outside corporate I mits. C. LENGTH OF STAY IN 16 c. CITY OR TOWN (I outside corporate limits, write RURAL and give nearest fown) write RURAL and give nearest town! Sykesville mos.27 days Silver Spring Pages d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite), give street address) a. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO 25 Wayne Av NAME OF Yeer DECEASED 9 1961 Featherstone Santmyers DEATH (Type or print) Dorothy August within 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH carbon 9. AGE (In years IF UNDER 1 YEAR) IF UNDER 24 HRS. lest birthday) Months White Female WIDOWED TO DIVORCED January 4, 1889 event, 100. JSUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY | 11. B-RTHPLACE (County & State, or foreign country) done during most of working life, even if retired) U.S.A. England Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please Clara Holt Harry Featherstone 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unkown) | (Ifyesgiva werprdates of service) Springfield Hospital Records 18. CAUSE OF DEATH [knter only one ceuse per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH þ PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease Years IMMEDIATE CAUSE (e) peusis burial-transit DUF TO attending been geva rise to immediate couse DUE TO (e), steting the underlying has certificate har use as the I PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? C.B.S. associated with cerebral arteriosclerosis. NO TO 20b DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 201 (City or town) (County) (Stata) factory, street, office bldg., etc.) Not While While Hour a.m. et work et work DIRECTOR: 8-9-, 1961..., and that death occured at 7:14, Rom the causes and on the date stated above. saw the deceased alive on 22b. DATE ATTENDING DIRECTOR death. TO FUNERAL I director, par PHYS. PHYS. PHYSICIAN S 22d. ADDRESS NAME (Type) Springfield Hospital, Sykesville, Md. Naci B. Buyukunsal, M.O. 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county) (State) REMOVAL (Specify) Parklawn Cemetery buria] Montgomery County 290ADDREST th St. N.W 250. REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE

Washington 9.

D. C. DATE UG 1 4 '61

Onther & King

VR A15 (4) 15M 9/60

24 FUNERAL DIRECTOR'S SIGNATURE

Hines Co.

The S.H.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 9001 director, iled with PLACE OF DEATH · COUNTY o STATE be filed MARYLAND the funeral should be fi CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 15 RAL and give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION HOMP GOLDEN A 8SING NAME OF Middle Last Filled DECFASED (Type or print) 6. COLOR OR RACE 5. SEX 7. MARRIED T NEVER MARRIED TO DATE OF BIRTH after DIVORCED WIDOWED [papers. comple 10a. USUAL OCCUPATION G ve kind of work done 10b KIND OF BUSINESS OR INDUSTRY | 11 during most of working life, even if retired) pup = 72 carbar 13. FATHER'S NAME 14 MOTHER'S MAINEN NAME physician remove 17 INFORMANT WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. attending please CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (c) the XXXXX څ Conditions, if any, which ARTERIOSCLEROTIC HEART DISEASE permit gove rise to immediate DUF TO couse (a), stating the under-ADVANCED SENILE CHANGES lying cause last.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) IS RESIDENCE ON A FARM? YES NO 4. DATE Month Day Yeor DEATH 190 9. AGE In years IF UNDER 1 YEAR IF UNDER 24 HRS last birtivacy) Months Days Hours 12 CITIZEN OF WHAT COUNTRY? BIRTHPLACE (State or fareign caunity) Addoess INTERVAL BETWEEN ONSET AND DEATH HYPERTENSIVE CARDIOVASCULAR DISEASE 20 Yrs 20 Yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1/03/19. WAS AUTOPSY PERFORMED? YES NO IX 20g ACCIDENT WAS UNDERLYING
OR CONTRIBUTING
CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part 1 or Port 11 of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY 20e PLACE OF INJURY (Hame, farm, 20f. (City or lown) Doy, Year 20d. INJURY OCCURRED (Stote) (County) factory, street, office bldg., etc.) Hour o. m. While Not while of work at work p. m. 21 I certify that (I) (this haspital) attended the deceased fram, 1935 19 , tal August , 19 61, that (i) (we) last 1901, and that death accurred at 8:45P this the causes and on the date stated above saw the deceased alive an L AUFUST 226 SIGNATURE 22b DATE SIGNED ATTENDING PHYS STAFF PHYS DIRECTOR -8/1/61 COURS OF 22c PHYS CIAN'S 22d ADDRESS NAME (Type) H. Lawson, Jr., M.D. Liberty Rd at Eldersburg, Sykesville, Md. 230 BUR AL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City fown, or county) REMOVAL (Specify) 24, FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 250 REC'D BY REGISTRAR

¹61

arthur S. Frank

DAUG

attending physician. **burial-transit** cremation, certificate After detached DIRECTOR: å 3 shauld FUNERAL poge the St

0 VR A15 (4) 15M 9/59



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS -- BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 9002 director, iled with PLACE OF DEATH 2, USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed o COUNTY **b.** COUNTY MARYLAND funeral b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest lown) RURAL and give nearest loven) d. NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO P Middle NAME OF DATE Year Doy DECEASED DEATH (Type or print) 19 9. AGE In years SUNDER I YEAR IF JNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE/OF BIRTH lost birthday) Months Doys Hours WIDOWED Z DIVORCED [100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY W. BIRTHPLACE (Sable or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if ratired) pou 2 14. MOTHER MAIDEN NAME 13. FATHER'S NAM .⊆ physicion 8 With remove WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO T. INFORMANT Address offending eose INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH [Enter only one couse per line fog (o), (b), and (c)ā PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO þ Conditions, if any, which gned gove rise to immediate per DUF TO couse (a), stating the underlying couse lost. Ь peeu PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): 19 WAS AUTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, | 20f. (City or town) Doy, Year 20d INJURY OCCURRED (County) (Stole) foctory, street, office bldg, etc. Hour o.m. While Not while at work at wark p. m. After 1961, to Certa Z6, 1961, that (1) (we) last 21 I certify that (I) (this hospital) attended the deceased from ached sow the deceased give on Living Tel-1961, and that death accurred to Tel. from the Jourses and an the date stated above DIRECTOR: 220 SIGNATURES 226 DATE SIGNED MED DIRECTOR 22c. PHYSICIAN'S NAME (Type) 22d ADDRESS FUNERAL CO 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown, or couply abod REMOVAL (Specify) 10 256, REGISTRAR'S SIGNATURE REC'D BY REGISTRAR AUG 31 VR ATS (4) DATE arthur & the 15M 9/59

)	1. PLACE OF DEATH O. COUNTY OFFICE	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE b. COUNTY RESIDENCE (Where deceased lived. If institution. Residence before admission)
	b CITY OR TOWN (If outside corporate limits, write RURAU and give neorest (5 min)	2 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	d NAMFOE HOSPITA. (If not in hospital, give street odd OR MSSTRUTION MURSING THE	dress)	d. STREET ADDRESS Co. IS RESIDENCE ON A FARM? YES NO
Î	3 NAME OF DECKASED (Type or print) MAR I BE	LLE SI	MON DEATH CHECKET 27 961
	5 SEX 6. COLOR OR RACE 7. MARRIED WIDOWED		B. DATE OF BIRTH Jan. 3, 1882 9. AGE/IN years IF UNDER I YEAR IF UNDER 24 HRS lost/foirthdoy) Months Days Hours Min
	10a. USUAL OCCUPATION (Give kind of work done 10b. KIN during most of working life, even if retired)	NO OF BUSINESS OR INDUS	STRY 11. BIRTHPLACE (Store or foreign country) 12. CITIZEN OF WHAT COUNTRY? 4. 5. A
	13. FATHER'S NAME		Emma Cuminghan
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, gave wor or dates of service,	CIAL SECURITY NO. 17 IN	WORMANT B. Simon - afore
	IB. CAUSE OF DEATH [Enter only one couse per line f PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO Conditions, if ony, which) (b) SCALE	rolered a	Moris , Certeres classing 1 9-26-50 teras elected beat Dis
	gove rise to immediate couse (a), stating the under- lying couse last.	entermin , C	2. W.A. + parking Dis. 8-27-61
	OIL	NTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	BE HOW INJURY OCCURRED	D. (Enter noture of injury in Port I or Port II of item 1B.)
	20c. TIME OF INJURY Month, Doy, Year 20d. INJU While of work	JRY OCCURRED 20e. PL/ Not while for ot work	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State clary, street, office bldg., etc.)
	21. 1 certify that (1) (this hospital) attended sow the deceased alive on $D = 2 \cdot I$	21	death occurred of F.M. from the causes and on the date stated above
	220 SIGNATURE	Holl	M.D. PHYS DIRECTOR PHYS 29 Aug 6
	NAME (Type) HOWARD E.	HALK	SYNESVILLE, MD.
	LIVERY 8-30-61	Drucy	R CREMATORY 23d LOCATION (City, town, or gounty) (Spote) Pringer Tribescalle, Bulle le, Md
	24, FUNERAL DIRECTOR'S SIGNATURE	Olypholovalle.	250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE

Pages 1 and 2 should be filed with TO HOSPI.—IR ATTENDING F. CELLI: The law requires that the death certificate be executed may be seed by the hospital strending physician.

TO FUNERAL DIRECTAL After this certificate has been signed by the attending physician and cample key filler page 3 should be distached for use as the bursal-transit permit. These pleases removed about a popers. Pages I the State Baard of Health prior to burial, cremation, or smarred, and in asy event, within 72 hours after death. VR A15 (4) 15M 9/59

after death. Page 4

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be do by the hospitol creating physicion.

NERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely fille 3 shauld be detached far use as the burial-tronsit permit. Then please remove corban papers. Pages tate Board of Health priar to burial, cremotion, or removal, and in any event, within 72 hours after death.

TO HOSPI

VR A 15M

Page the S	
15 (4) 9/59	91

						. 17 4 17
1, PLACE OF DEATH o. COUNTY	MARYLAND	2. USUAL RESIDENCE (Whe		ved. If institution b. COUNTY		
b CITY OR TOWN (If cutside carporote limits write		Maryl		P' - fa Dalle	Carrol	
RURAL and give nearest town)	C. LENGTH OF STAT IN ID	c. CITY OR TOWN (If ou			KAL ONG BIVE NE	diesi iown)
Rural Taneytown	6 years	Rural	Taney	own		
d. NAME OF HOSPITAL (If not in hospital, give stree OR INSTITUTION	† oddress}	d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED	Middle	Last	4. DATE	Month	D	ay Year
(Type or print)	Virginia	Smith	OF DEATH	Augus	st 1	5. 19 61
S. SEX 6. COLOR OR RACE 7. MAR		8. DATE OF BIRTH	9.	AGE (in years	F UNDER 1 YEA	R IF UNDER 24 HRS
Female White WIDOW		Sept. 27, 189	ø	last birthday) [Manths Days	Haurs Min
TOMOREO INTELOC	100 mm				12 CITIZEN C	F WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				,,		
Laborer C	anning Factory	Maryland 14. Mother's Maiden N	AME		Ues	5.A.
				3		
J. Maurice Angell		Sarah Ireh	e Shoe	maker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 [Yes, no. or unknown] (If yes, give wor or dates of service))	IFORMANT		Addres		
No 2	214-36-9090 Mr	. George W. A	ngell,	R #2, Ta	aneytown	n, Md.
18. CAUSE OF DEATH [Enter only one couse per	line for (a), (b), and (c).]					ERVAL SETWEEN
PART I. DEATH WAS CAUSED BY:	cuite Coron	con anten	L Coc	alung	-Le_ 7	eur mi
DUE TO				- 4		
Conditions, if any, which)	nouse a	reture Tu	soff		, (e who
gove rise to immediate					7	
lying cause last	aronany 6	letterisses	lense	i	'	2 yrs
/ 10]	CONTRIBUTING TO DEATH BUT				N. INI PART 1/ml	19. WAS AUTOPSY
47		~ *	4	ONDITION OTTE	ana eser ifet	PERFORMED?
3 Jewace		nevolenz	-5CL	-f ' 101		YES 🗍 NO 🗗
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	SON BE HOW INJURY OCCURRE	D. (Enter nature at injury in P	art I ar Port II	of item 18.)		
20c. TIME OF INJURY Month, Doy, Year 20d.	for a	ACE OF INJURY (Hame, farm,	20f. (City or	town)	(County) (State)
20c. TIME OF INJURY Month, Doy, Year 20d. Hour o. m. p. m. 19 of two	e Nat while Tac	tary, street, affice bldg., etc.	1			
		1/55/40 10	. 4	2//5-	20/01	
21 I certify that (I) (this haspital) atten						hat (I) (we) last
saw the deceased alive an 319	19 <u>G1</u> , and that d	leath accurred at 4.7	M, fram th	e causes and	an the dat	
K. S. MeVa	ugh		D RECTOR []	STAFF PHYS.		8/16/61
PAME (Type) R. S. Mc V	augh	22d. ADDRESS	engl		Tues	4.
23a BURIAL, CREMAT ON, 23b. DATE THEREOF	23c NAME OF CEMETERY O	R CREMATORY	23d LOCATIC	N (City, town, or	county)	(State)
REMOVAL (Specify)	61 Reformed Ce		_ *	town, Ma		(0.0.0)
Burial August 17, 19 24 FUNERAT DIRECTOR'S S.GNATURE	ADDRESS		BY REGISTRA		RAR'S SIGNATI	URÉ
fred as It. XLR (VI)		1.1				
C.O.Fuss & Son I	laneytown, Mary	LATIC DATE		- CM	hur S. the	LLR



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

NONUS

		9005		CEKTIFI	CA	IE OF DEATH		_	- 13	<u> </u>
1	o. COUNTY Car	rroll		MARYL	AND	o STATE Maryla	nere deceased nd			fore admission) ery Co.15
1	b. CITY OR TOWN (IF RURAL and give no Sykesville	outside corporate limit orest town)	s, write	c. LENGTH OF STAY I	N 1b	e. CITY OR TOWN (IF a		te límits, write RU	IRAL and give i	nearest town)
	d. NAME OF HOSPITA OR INSTITUTION Springfia	AL (If not in hospitol, gi				d street address 4308 Landg	reen S	treet		e is residence on a farm? yes \(\text{NO} \)
3	NAME OF DECEASED (Type or print)	John Firs	t	Middle Ge or	'ge	Stecher	4. DATE OF DEATH	Month 8		6 19 61
\$.	Male Male	6 COLOR OR RACE White	7 MARRI WIDOWEI	ED A NEVER MARRIEI D DIVORCED		8-4-1887	9	AGE (In years lost birthdoy) 14 yrs.	Months Doy	AR IF UNDER 24 HRS Hours Min.
100	USUAL OCCUPATIO during most of works Union own	ing life, even if retired)		KIND OF BUSINESS OR Books	INDUS	Washingto		intry)	U.S.A	OF WHAT COUNTRY?
13.	FATHER'S NAME し	oseph Stec				Mary Ba				
15 (Ye		IN U. S. ARMED FORG	Unice) OI	SOCIAL SECURITY NO PROPERTY NO		FORMANT OSpital recor	ds.	aykes	ville,M	d.
		TH [Enter only one cou TH WAS CAUSED BY: IMMEDIATE CAUSE (o)	A 201		tic	Heart Diseas	e.			TERVAL BETWEEN NSET AND DEATH YEARS
	Conditions, if on gove rise to in couse (o), stating t lying couse lost	nmediate (neralized A	rtei	riosclerosis				years
CERTIFICATION								19. WAS AUTOPSY PERFORMED? YES NO		
MEDICAL	20c. TIME OF INJURY Hour o. m. p. m.									
	21 I certify that	t (I) (this haspital) ed alive an 8-2	gttende	61	1 (2)(1)	8- 17 eath accurred at 8	5	8 –26– he causes and		that (I) (we) last te stated abave.
	220. SHONATURE	tin de	16	Eumpo	. 1		ED IRECTOR [STAFF PHYS		22b. DATE 8-26-196
	22c PHYSICIAN'S NAME (Type,	Agustin	del (Campo M.D.		Springfiel	d State	e Hospit	al.Syke	sville.Md.

23a BUR AL CREMATION REMOVAL (Specify) Burial

1 3

236 DATE THEREOF

23c NAME OF CEMETERY OR CREMATORY Glenwood Cemetery
,Silver Spring, Md.

23d LOCATION (City, town, or county)

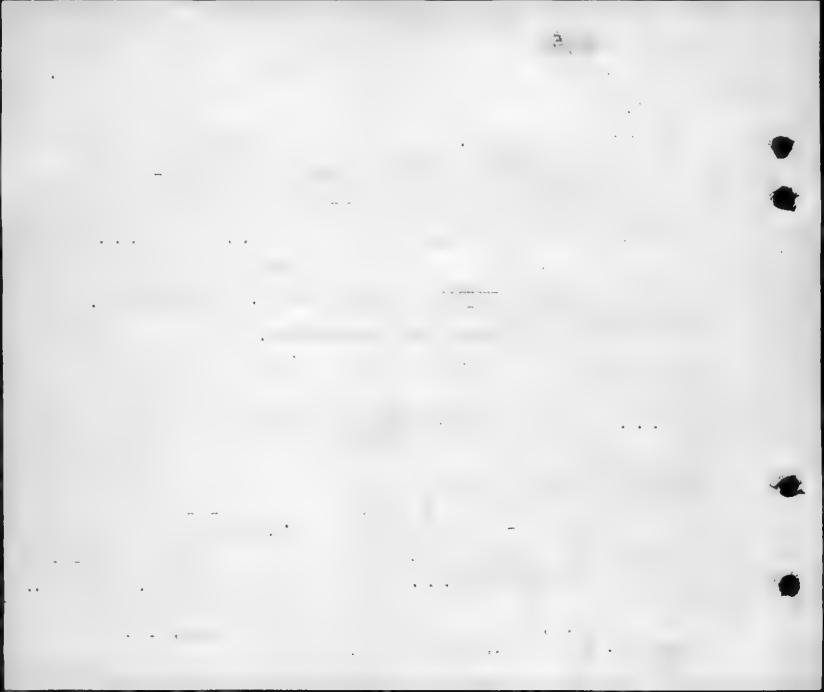
(Stofe)

24 FUNERAL DIRECTOR'S SIGNATURE WATNET E. Pumphrey

Wachington DC 250. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE DATE AUG 2 9 '61

- 11 mg & House

VR A1S (4) 15M 9/59



after death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH
ON OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

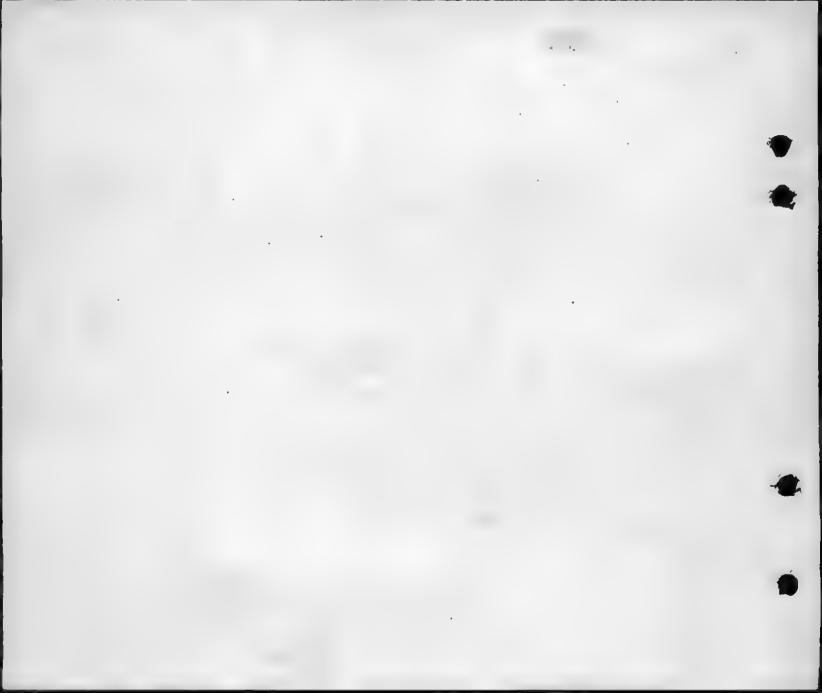
TO MOISION OF	STATISTICAL RESEARCH MAD	KECOKD3 - DALIIM
9006	CERTIFICATE	OF DEATH

(1	۶	9	9	8	
	=					

,	o. COUNTY MARYLAND	a. STATE A A D. I D. 2. B. COUNTY A D.							
-	b. CITY OR TOWN (If aulside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If butside corporate limits, write RURAL and give nearest tawn)							
<	Sykesyile - Rural Life	SYKESVILLE - RUCAL							
	d. NAME OF HOSPITAL (If not in haspital, give street address)	d. STREET ADDRESS e. IS RESIDENCE							
1	PINE Knob Road	Pine KNAD ROAD YES NO SO							
3	3 NAME OF First Middle	Last 4. DATE Month Day Year							
П	(Type or print) Gertrude R.	Stout DEATH AUGUST 24 1961							
5	5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8	DATE OF BIRTH 9. AGE TM years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min							
	Female White WIDOWED DIVORCED	11-25-1818 82415							
10	10a. USUAL OCCUPATION (Give kind of work done during most of warking life, even if retired)	Y 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY?							
	House Wife	14, MOTHER'S MAIDEN NAME							
13	E	No. 10 1 / 10 1 4							
15.	15, WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17, INFO	RMANT Address							
	(Yes. no, or unknown) (If yes, give wor or dates of service)	S. Elizabeth Parks - Baltimere Md							
F	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN							
	PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Quelus - exces	y Edlena 24 Rome							
	DUE TO DO DE LO 10								
	Conditions, if any, which) (b) Chi. Least feel luit 10 yes.								
	gove rise to immediate out to the course (a), stating the under-								
7	lying couse lost. (c)	DT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY							
TION	PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO	DT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 10							
IFIC	200 ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED	(Enter nature of injury in Port I or Port II of item 1B.)							
CERTI	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	,							
JA.	Z 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE	E OF INJURY (Home, farm, 20f. (City or town) (County) (State)							
MEDICAL	Hour a.m. While Not while factor p. m. 19 of work of work	y, street, office bldg., etc.)							
	21 I certify that (I) (this hospital) attended the deceased from	3 , 14 , 1961, to 81 2 1 1961, that (1) (we) last							
	2 14 //	oth accurred of M. from the causes and on the date stated above.							
	220 S GNATURE COLLECTION	ATTENDING MED STAFF 226 DATE							
	22c PHYSICIAN'S	D. PHYS D RECTOR PHYS							
	NAME (Type) Sani Okutman	22d. ADDRESS Soykesville, Hd.							
23	23a BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR C	CREMATORY 23d LOCATION (City, fown, or caunty) (State)							
	REMOVAL (Specify) 8-26-61 Wesley Fr	recom CARROLL Md.							
24	24. FUNERAL DIRECTOR'S SIGNATURE // ADDRESS	MA / 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
L	Luther H. Haight Sykesville	//ll, DATE AUG 28'61 Cotton & Kines							

TO HOSPIT OR ATTENDING PY CIAN: The law requires that the death certificate be executed any be recorded by the hospital contention physician.

TO FUNERAL DIRECTOR: After this benificate has been signed by the attending physician and campleted fille page 3 should be detached for use as the burial-transit permit. Then please remaye carbon papers. Pages the State Board of Health prior to burial, cremation, or removal, and in any meent, within 72 hours after death VR A15 (4) 1SM 9/59



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

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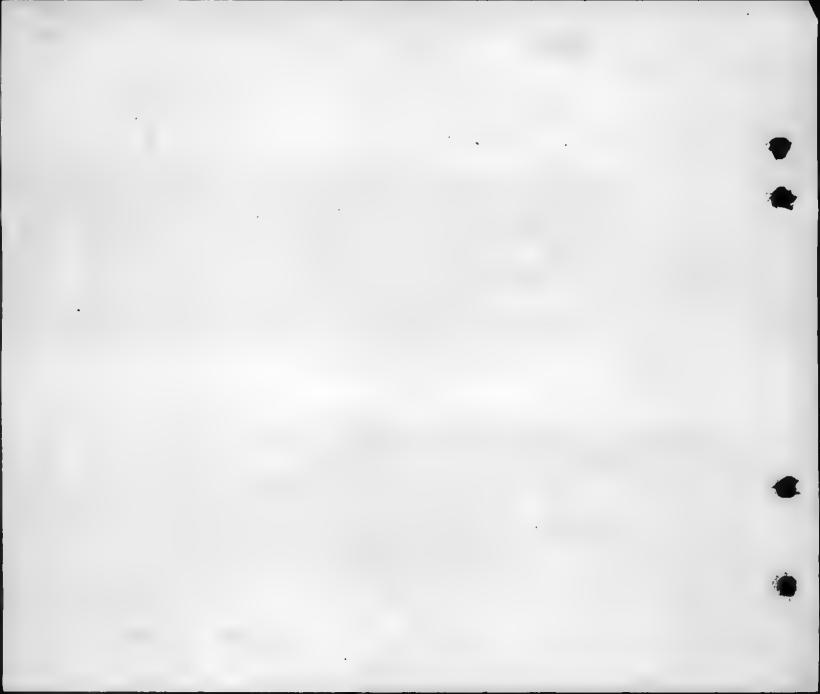
-	91117 CERTIFICATE OF DEATH
1)	1. PLACE OF DEATH a. COLONITY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND
1	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d NAME OF HOSPITAL (If not in pospital, give street address) OR INSTITUTION O
,	S. SEX 6 COLOR OR RACE 7. MARRIED TREVER MARRIED 8. DATE OF BIRTH 9. AGE (In yours Funder 1 year Funder 24 HRS Month Day Year Year Funder 24 HRS Ost birthdoy) Months Days Hours Min
	AMAIL WIDOWED DIVORCED WORKED WIDOWED DIVORCED WAS A Min Months Doys Hours Min Min Doy Wrs Min Doys Hours Min Doy Wrs Min Doys Hours Min Doy Wrs Min Doys Hours Min Doys Ho
(1	13. FATHER'S NAME 14. MOTHER'S, MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT
	(Yes, no, or unknown) (If yes, give wor or deres of service) Thanks T. Thanks W.S. (Australia of Service) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) The Conclusion of Services of Services Thanks T. Thanks T. Thanks W.S. (Australia of Services) INTERVAL BETWEEN ONSET AND DEATH These of Services of Serv
	Canditions, if any, which gove rise to immediate cause (a), stating the under-lying couse last. DUE TO Canditions, if any, which gove rise to immediate cause (a), stating the under-lying couse last. (c)
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 12. 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)
	OR CONTRIBUTIONS
	21 I certify that (I) (this haspital) attended the deceased fram & -/8
1	ATTENDING MED DIRECTOR STAFF PHYS. STAFF 22c PHYSIC AN'S NAME YTYPE) THE STAFF ATTENDING MED DIRECTOR STAFF PHYS. STAFF PHY
	230 BURIAL, CREMATION, 23b DATE THEREOF 23c DAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stole) 23 BURIAL, CREMATION, 23b DATE THEREOF 23c DAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stole) 24 EUNERAL DIRECTOR'S SIGNATURE ADDRESS 25d. REC'D BY REGISTRAR'S SIGNATURE
	4. 2. muso, A. Westminter Fred DATE AUG 3 Y'61 Outlan & Knows

VR A15 (4) 1SM II/S9

the funeral director, shauld be filed with

and 2

after death. Page



PHYSICIAN: The law requires that the death certificate TO ROS AT death. Fige 4 of 12 of 12 director, page 3 of 5 be filed with the

			ı	7
	s certificate has been signed by the attending physician and completely filled in by the funeral	or use as the Eurial-transit permit. Then please remove carbon papers, Eages 1 and 2 should	prior to burial, cremation, or removal, and in any event, within 72 hours after death.	
	hysician and	remave carb	any event, w	
	attending ph	Then pleasm	e ni pue, levo	
physician.	igned by the	nsit permit.	tion, or remo	
e hospital or attending physician.	e has been si	he burial-trai	burial, cremat	
e hospital	s certificate	or use as 1	prior to b	

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 0000

	9000	CE	RTIFICAT	TE OF DEATH		08999
1.	PLACE OF DEATH	a see			CE (Where deceesed lived, If institutions	Residence before edmission)
	Carroll		MARYLAND	e. STATE Maryl	and 6. COUNTY Ca	rroll
	b. CITY OR TOWN (if outside corporete limits, write RURAL and give necess town)	c. LENG	TH OF STAY IN 18	c. CITY OR TOWN (I	f outside corporete limits, write RURAL et	nd give nearest town)
	Sykesville		nths 2½	Westminst	er, Md. Rt. 5 Box36	
	d. NAME OF HOSPITAL OR INSTITUTION (if not i	n hospital, give	street address)	d. STREET ADDRESS		a. IS RESIDENCE ON A FARM?
	Springfield State Hosp:	ital		1		YES NO
3.	NAME OF First		Middle	Last	4. DATE Month	Day Year
	(Type or print) Marv	1	Bervl	Warehime	DEATH August) ₁ 19 6I
5.	SEX 6. COLOR OR RACE 7. MA	ARRIED NEY	ER MARRIED	B. DATE OF BIRTH	9. AGE (In years IF UNDER	Service Application of the Control o
]		OWED 🗌	DIVORCED	October 6,99	6T yrs. Months	Deys Hours Min.
10e	. USUAL OCCUPATION (Give kind of work 16	S. KIND OF BU	SINESS OR INDUS		ty & State, or foreign country) 12. Cf	TIZEN OF WHAT COUNTRY?
00	ne during most of working life, even if relired) Housewife	min min		Unknown	MARYLAND W	115 A
13.	FATHER'S NAME			14. MOTHER'S MAIDEN	NAME	Tyrana 00//
	Charles Mitten			Ann Arnold		
	WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL S	ECURITY NO. 17.	INFORMANT	Address	
(Ye	No (If yes give we ror detes of service)	2711	12-I905	Springfiel	d Pasanda (Hagnita	1)
	18. CAUSE OF DEATH [Enter only one ceuse		Y	obi.rugi.fer	d Records (Hospita)	INTERVAL BETWEEN
	DADT I DEATH WAS CAUSED BY.					ONSET AND DEATH
	MMEDIATE CAUSE (6)	Recurren	nt C.V.A.			Days
	DUE TO					
	Conditions, if any, which (b)					
	gave rise to immediate couse (e), stelling the underlying DUE TO					
	couse lest. (c)					
O	PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING	TO DEATH BUT	NOT RELATED TO THE TERMIN	NAL DISEASE CONDITION GIVEN IN PAR	17 1(a) 19. WAS AUTOPSY PERFORMED?
ATI	Circulatory disturbance	.Cerebi	cal arter	iosclerosis-	Diabetes Mellitus	YES NO
F	20e. ACCIDENT WAS UNDERLYING [1 20b.			ED. (Enter neture of injury in I		
CERTIFICATI	OR CONTRIBUTING CAUSE OF DEATH					
AL	20c. TIME OF INJURY Month, Day, Year 1	20d. INJURY O	CCURRED 20e, P	LACE OF INJURY (Home, ferm	, 20f. (City or lown) (Co	unty) (Sleta)
MEDICAL		While Not	A Miles	ectory, street, office bldg., etc.	1	
×	Dealt +3		vork	II O/ TO/T		/ T
	21. I certify that (I) (this hospital) a					
	saw the deceased alive on August	19	and th	at death occured atLL	120, from the causes and on	
	220. SIGNATURE	20111	PNB.	ATTENDING A	MED, STAFF	226, DATE SIGNED
	Marie Congres	cert	160	M.D. Ind	DIRECTOR PHYS.	August 5, 196
	22c. BHYSICIAN'S NAME (Type)			22d. ADDRESS		
	Julian Radevi	cowvez.	C.D.	Springf	ield State Hospital	-Sykesville-L
23	BURIAL, CREMATION, 235. DATE THEREOF		AME OF CEMETER	Y OR CREMATORY	23d. LOCATION (City, town or cour	
"	PENOVAL (Specify) AUG-8-196	1 K	RIDER	5	WESTMINSTER	MD
24			DDRES5		D BY REGISTRAR 256. REGISTRAR'S	
1	VIVISIANTON	n/	13711	reduce DATE A	UG 8 '61 Civiling.	S. Kines
	VX / COURCE	16		The state of the s		

233 A STATE OF THE STA an est fithmen as and the state of t MAN TO THE PARTY OF THE PARTY O (Textended) alternated at a state of the sta and the local fit was to the Land step and many penuting the god at self-blant in it all the later attention THE RESIDENCE OF THE PROPERTY AND SURECLES That Eligenian will be a

CIN FOR STATE HEALTH DEPT. TO DEFOTY MEDICAL EXACTIVER: This certificate should be executed within 24 hours after 1. If the lotter is necessary, please emecute the certificate, writing the word "pending" in pendi in them 18. Give Pages 1, 2, and 5 to the tuneral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be relatined for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Sale and of Heelth, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 09000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

	CHILIP						and the same
1. PLACE OF DEATH	P004		2. USUAL RESIDEN	CE (Where dece		n: Residence before e	dmission
	rroll	MARYLAND	o. STATE Mary	yland	b. COUNTY	Carroll	
	if outside corporete limits,	c. LENGTH OF STAY IN 16	CITY OR TOWN (If outside corpore	te limits, write RURAL	end give neerest tow	(n)
	give neerest town)		Win	ksburg			
	Inksburg TAL OR INSTITUTION (if not in hi	ospital, give street address)	d, STREET ADDRESS			a. IS R	ESIDENCE
_			1 .			YES T	A FARM?
3. NAME OF	D. I	Middle	Last Re	Da L	Month	Dey Yee	-
DECEASED		Middle		OF			
(Type or print)	HARVIE	1	WILSON	DEATH	August		61
5. SEX	6. COLOR OR RACE 7. MARR	JED W NEVER MARRIED 8	DATE OF BIRTH		AGE (In years IF UND est birthdey) Month		
Male	White widow	PED DIVORCED	Just. 31	906	Months	Deys Hours	Min.
done during most of wo E/C <	10N (Give kind of work thing life, even if relited) 10b. 11 A A A A 10b.	KIND OF BUSINESS OR INDUSTR	VIF915	11a	12.	CITIZEN OF WHAT C	OUNTRY
		S. SOCIAL SECURITY NO. 17.	W 11		Address		-
	fyesgive werordelesofservice)	17-11-17/5	B. H. N	lson	Finhsle	m.	
	~	11-14 1/19	sarry No	charge	Timpson		
BART L DEAT	EATH [Enter only one cause per		·			ONSET AND	
PARI I, DEAI	H WAS CAUSED BY:	cardial Infarct:	ion			1	
	DUE TO						
Conditions, if any	which \ (b) T	prombosis of Ri	ht. Chronery	Artery			
gave rise to immed	lete ceuse		B	330 0003			
(a), stating the u	nderlying	Ambandanal amak	to Heave Me				
Cause lest.	R SIGNIFICANT CONDITIONS CO	Arteriosclerot:			NOTION GIVEN IN P	APT Male 10 WAS A	HITODSY
E PARI U. OTHER	SIGNIFICATO CONDITIONS CO	ATTRIBUTION OF THE	A KEEP TO THE TERMIN	INTE DISCUSE CO	NOTION OFFICE INT	PERFO	DRMED?
5						YES T	NO 3
PART II. OTHER	INTRIBUTING []	RIBE HOW INJURY OCCURED. (E	inter neture of injury in Per	rt I or Pert II of ite	em 18.)		
20c. TIME OF INJU Hour e.m. p.m.	JRY Month, Day, Year 20d Whi 19 at w	ileNot While fect	CE OF INJURY (Home, ferr ory, street, office bldg., etc		r town) (County)	(Stete)
21. I certify th	nat I took charge of the re	mains described above, he	ld an Autopsy 🗶	Inspection	, Inquiry	and in my o	pinion
death resulted	from: Natural causes	Cocident Suic	de . Homicide	, Unde	termined manner		
	07		CHIEF MEDICAL	EXAMINER			
ACTUAL	Whales S.	1		DICAL EXAMINER	X	DATE SIG	INED
SIGNATURE	-	A	DEPUTY MEDICA	L EXAMINER		8/11/	61
EXAMINER'S NAME (Type)	Charles S.	Petty M.D.		city, lown, or cou	intyl	0/11/	OT
20. BURIAL, CREMATIC	ON, 226. DATE THEREOF	224. NAME OF CEMETERY OF			N (City, town, or cou	ntry) /(Stet	te)
REMOVAL Specify	1 11	ann W	lount	Balt	1111 200	Md	
23. FUNERAL DIRECTO	1 14/61	MADDRESS	240. REC	C'D BY REGISTRA	R 1 24b. REGISTRAR	S SIGNATURE	
F. S	line Ams	Rusterston	n Med DAAUG		Outhur &		
7 1	And an interest		,		- Passining -	- / Laure	

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